# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

**A.** The **State** of **North Dakota** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

**B. Program Title:**
**Traditional MRDD Home and Community Based Services Waiver**

**C. Waiver Number: ND.0037**
**Original Base Waiver Number: ND.0037.**

**D. Amendment Number:**

**E. Proposed Effective Date:** *(mm/dd/yy)*
10/01/12

**Approved Effective Date of Waiver being Amended: 04/01/09**

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:
The purpose of the amendment, control number control number: ND.0037, is to make changes to the specifications limits on the amount, frequency, or duration of services under the following sections:

-the Equipment and Supplies service section clarifying pre approval from the Department is required before the service can be authorized and when generic technical devices that are used by other family members how much the Department will allow.

-the In-Home Supports service section
clarifying the amount of hours that can be used for respite care,
removing the language that states 'and the exception is anticipaed to be neeed for less than 3 months', and
clarifying at what age the individual is allowed to use day care under this service.

### 3. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☐ **Waiver Application** | |
| ☐ **Appendix A – Waiver Administration and Operation** | |
| ☐ **Appendix B – Participant Access and Eligibility** | |

| Component of the Approved Waiver | Subsection(s) |
|---|---|
| ☑ Appendix C – Participant Services | C-1/C-3 |
| ☐ Appendix D – Participant Centered Service Planning and Delivery | |
| ☐ Appendix E – Participant Direction of Services | |
| ☐ Appendix F – Participant Rights | |
| ☐ Appendix G – Participant Safeguards | |
| ☐ Appendix H | |
| ☐ Appendix I – Financial Accountability | |
| ☐ Appendix J – Cost-Neutrality Demonstration | |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

# Application for a §1915(c) Home and Community-Based Services Waiver

## 1. Request Information (1 of 3)

**A.** The **State** of **North Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
**Traditional MRDD Home and Community Based Services Waiver**

**C. Type of Request: amendment**

**Requested Approval Period:** *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

**Original Base Waiver Number: ND.0037**
**Draft ID: ND.07.06.11**

**D. Type of Waiver** *(select only one):*

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 04/01/09**
**Approved Effective Date of Waiver being Amended: 04/01/09**

## 1. Request Information (2 of 3)

**F. Level(s) of Care**. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

- ☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
The State additionally limits the waiver to individuals with mental retardation or individuals with related conditions and cognitive impairment.

## 1. Request Information (3 of 3)

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates** *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligiblity for Medicaid and Medicare.**

Check if applicable:

☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
North Dakota's Home and Community-Based Waiver for Individuals with Mental Retardation/Developmental Disabilities provides service options for an array of home and community-based services in the least restrictive environment. The goal of the waiver is to provide a consumer-centered service delivery system assuring health and welfare, participant rights and safeguards, as well as financial accountability for all residential, day, family support and supported employment services to all eligible individuals meeting the ICF/MR level of care.

To accomplish this goal, an array of services are offered through the waiver. A system is in place to assess the needs of the consumers, implement a Person Centered Plan, monitor the progress of the Person Centered plan and re-evaluate consumer needs on a regular basis. Coordinated individual, program and system level discovery, remediation and verification procedures are being modified and will continue to be assessed and adjusted as needed.

## 3. Components of the Waiver Request

**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

**A. Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

## 4. Waiver(s) Requested

**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

**C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

**No**

**Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

**Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

**In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:**

**A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

**B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

**C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

**D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

**E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

**F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

**G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

**H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

**I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

***Note: Item 6-I must be completed.***

**A. Service Plan**. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

**B. Inpatients**. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

**C. Room and Board**. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

**D. Access to Services**. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

**E. Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

**F. FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

**G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the

severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:
DD Program Managers, DD Program Administrators, Licensed DD Providers, ND Protection and Advocacy, Experienced Parents and DD Advisory Committee were invited to participate in video conference-based stakeholder meetings, a brown bag lunch, and smaller workgroups to provide input into the waiver renewal application. The resulting application has been made available via website access and by hard copy upon request. Additionally, copies were sent to the Tribal Councils of the four Reservations in North Dakota. Written comments were accepted from Tribal entities for 60 days. Other stakeholders were also invited to submit written comments.

The DD Division reviewed all written comments and made changes where appropriate.

**J. Notice to Tribal Governments**. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**
Krein

**First Name:**
Marella

**Title:**
Administrator

**Agency:**
Developmental Disabilities Division

**Address:**
1237 West Divide Avenue, Suite 1A

**Address 2:**

**City:**
Bismarck

**State:**
**North Dakota**

**Zip:**
58501-1208

**Phone:**
(701) 328-8977 **Ext:** ☐ **TTY**

**Fax:**

(701) 328-8969

**E-mail:**

mkrein@nd.gov

**B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:
**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**
**North Dakota**
**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances

specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**
**North Dakota**
**Zip:**

**Phone:**

**Ext:** **TTY**

**Fax:**

**E-mail:**

## Attachment #1: Transition Plan

Specify the transition plan for the waiver:

The State made the decision to combine the two waivers to allow more flexibility for individuals and families receiving waiver services. Although most services are currently available within both waivers, some supports were only available in one waiver. With the combining of the two waivers, an individual will now be able to self direct In Home Supports and receive agency directed Day Habilitation.

Some service limitations and prohibited service combinations remain, however, there will be more options available to individuals than there were

before. In addition to the increased accessibility for individuals and families, combining the two waivers will be more efficient for the State as it relates to administration and management of the waiver including waiver slots.

The Reserved slots in the Traditional waiver will remain the same. No additional reserved slots will be created by the combination of the two waivers. The slots that recipients are currently assigned to within the Self Directed Supports waiver will transfer with them to the new combined waiver. The combined waiver will not reserve a specific number of slots solely for self directed supports.

Participants currently in the Self Directed Supports waiver will not have to change providers and can continue with self-directed services.

A Public Notice as well as a notice to Tribal members will be issued with the submittal of this amendment. A notice to the Self Directed Supports waiver participants will also be issued upon approval of the amendment. A copy of the proposed notice letter to the Self Directed Supports waiver participants was sent to CMS at the time of the initial submittal of this amendment. It was subsequently recommended, by CMS, that the proposed letter, with a date of February 15, 2011, be sent to participants at that time. The DD Division will assure that the notice letter is sent out at that time.

The Developmental Disabilities Division does not feel that this amendment will have a negative impact on any individual including members of the North Dakota Indian Tribes.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ◉ **The waiver is operated by the State Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   *(Do not complete item A-2)*

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   **Developmental Disabilities Division**
   *(Complete item A-2-a).*

   ○ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other State and local/regional non-state agencies (if appropriate) and contracted entities. The North Dakota Department of Human Services is the single State Medicaid Agency which includes the DD Division and Medical Services. The DD Division, which is a divison within the single Medicaid Agency, is responsible for the daily administration and supervision of the waiver, as well as issues, policies, rules and regulations related to the waiver. Oversight of waiver activities is assured through the Department's quarterly waiver coordination meetings which include representatives from Medical Services and units administering waivers.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   **As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Contract for Fiscal Agent services for waiver supports that are participant directed.

   ○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

   ◉ **Not applicable**

   ○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
   Check each that applies:

   ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   *Specify the nature of these agencies and complete items A-5 and A-6:*

   ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The ND Department of Human Services, Developmental Disabilities Division, will monitor the Fiscal Agent contract per department contract oversite protocol.

## Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Fiscal Agent activities will be continually monitored by families and Program Managers through on-line individual balance sheet reports. Feedback will be solicited from staff working with the Fiscal Agent to measure satisfaction with current contractor.
The Department of Human Services will also monitor monthly contract billings.

The contract will be monitored at least every 6 months following the Department of Human Services contract oversight procedures.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

| Function | Medicaid Agency | Contracted Entity |
|---|---|---|
| **Participant waiver enrollment** | ☑ | ☐ |
| **Waiver enrollment managed against approved limits** | ☑ | ☐ |
| **Waiver expenditures managed against approved levels** | ☑ | ☑ |
| **Level of care evaluation** | ☑ | ☐ |
| **Review of Participant service plans** | ☑ | ☐ |
| **Prior authorization of waiver services** | ☑ | ☐ |
| **Utilization management** | ☑ | ☐ |
| **Qualified provider enrollment** | ☑ | ☐ |
| **Execution of Medicaid provider agreements** | ☑ | ☑ |
| **Establishment of a statewide rate methodology** | ☑ | ☐ |
| **Rules, policies, procedures and information development governing the waiver program** | ☑ | ☐ |
| **Quality assurance and quality improvement activities** | ☑ | ☐ |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Administrative Authority**
***The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(A-1) Queries will be consistently run and data aggregated for review by the Developmental Disabilities Division and the Regional Program Administrators.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ASSIST Queries relative to participant enrollment, level of care evaluations, participant service plans, and the prior authorization of Waiver Services,**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify:<br>Every two years | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Every two years |

**Performance Measure:**
**(A-2) Quarterly meetings with the Waiver Coordinating Committee, chaired by the State Medicaid Director. The DD Division will present utilization data, demand, consumer and provider issues, and other issues as they arise. Minutes will be recorded and distributed.**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(A-3) The DD Division will monitor the contract with the fiscal agent on a quarterly basis. The data discussed with the fiscal agent at the quarterly meetings will include contract billing information,**

**utilization data from the FTP website, and issues obtained from DD Program Managers and families. Meeting minutes will be completed and distributed.**

**Data Source** (Select one):
**Meeting minutes**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(A-4) Percent of Providers meeting licensure requirements per NDAC 75-04-01.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Source** (Select one):
**Critical events and incident reports**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |

| | | |
|---|---|---|
| | **Continuously and Ongoing** | **Other**<br>Specify: |
| | **Other**<br>Specify: | |

**Data Source** (Select one):
**On-site observations, interviews, monitoring**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| **State Medicaid Agency** | **Weekly** | **100% Review** |
| **Operating Agency** | **Monthly** | **Less than 100% Review** |
| **Sub-State Entity** | **Quarterly** | **Representative Sample**<br>Confidence Interval = |
| **Other**<br>Specify: | **Annually** | **Stratified**<br>Describe Group: |
| | **Continuously and Ongoing** | **Other**<br>Specify: |
| | **Other**<br>Specify: | |

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Consumer surveys**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| **State Medicaid Agency** | **Weekly** | **100% Review** |
| **Operating Agency** | **Monthly** | **Less than 100% Review** |
| **Sub-State Entity** | **Quarterly** | |

| | | |
|---|---|---|
| | | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☑ **Stratified**<br>Describe Group:<br>By service, by age, by provider, |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Issues identified, yet not resolved at the meetings, will be assigned to workgroups to resolve. The issue will be placed on the agenda and revisited at the following quarterly meeting. The DD Division has regularly scheduled Program Staff Meetings to review waiver issues as identified.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>As issues are identified. |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The Developmental Disabilities Division will design Quality Improvement job activities which will include conducting individual consumer and provider monitoring activities. The Quality Improvemnt job activities will be developed by January 1, 2010.

Protocols for "Quick Checks" observational tools which will provide a structure to identify health and welfare issues and opportunities for increased inclusion will be developed by 1-01-10.

The DD Division will enter into a memorandum of understanding with partners such as the Council for Quality and Leadership (CQL) regarding data collection and aggregation. The initial MOU will be developed by 1-01-10.

# Appendix B: Participant Access and Eligibility

## B-1: Specification of the Waiver Target Group(s)

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| ○ **Aged or Disabled, or Both - General** | | | | | |
| | ☐ | **Aged** | | | ☐ |
| | ☐ | **Disabled (Physical)** | | | ☐ |
| | ☐ | **Disabled (Other)** | | | ☐ |
| ○ **Aged or Disabled, or Both - Specific Recognized Subgroups** | | | | | |
| | ☐ | **Brain Injury** | | | ☐ |
| | ☐ | **HIV/AIDS** | | | ☐ |
| | ☐ | **Medically Fragile** | | | ☐ |

| Target Group | Included | Target SubGroup | Minimum Age | Maximum Age | |
|---|---|---|---|---|---|
| | | | | Maximum Age Limit | No Maximum Age Limit |
| | ☐ | Technology Dependent | | | ☐ |
| ◉ Mental Retardation or Developmental Disability, or Both | | | | | |
| | ☐ | Autism | | | ☐ |
| | ☑ | Developmental Disability | 0 | | ☑ |
| | ☑ | Mental Retardation | 0 | | ☑ |
| ○ Mental Illness | | | | | |
| | ☐ | Mental Illness | | | |
| | ☐ | Serious Emotional Disturbance | | | |

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

The State additionally limits the waiver to individuals with mental retardation or individuals with related conditions and cognitive impairment.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

◉ **Not applicable. There is no maximum age limit**

○ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)* Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is** *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is** *(select one)*:

**The following dollar amount:**

Specify dollar amount:

**The dollar amount** *(select one)*

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**

Specify percent:

**Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

| Waiver Year | Unduplicated Number of Participants |
|---|---|
| **Year 1** | 4000 |
| **Year 2** | 4100 |
| **Year 3** | 4345 |
| **Year 4** | 4450 |
| **Year 5** | 4555 |

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

◉ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

| Waiver Year | Maximum Number of Participants Served At Any Point During the Year |
|---|---|
| **Year 1** | |
| **Year 2** | |
| **Year 3** | |
| **Year 4** | |
| **Year 5** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- **Not applicable. The state does not reserve capacity.**
- **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

| Purposes | |
|---|---|
| **Transition from Supported Employment to Extended Services** | |
| **Emergency** | |
| **Early Intervention** | |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Transition from Supported Employment to Extended Services

**Purpose** *(describe):*

In order to assure individuals have access to the placement, training, stabilization phase of supported employment, slots are reserved. Vocational Rehabilitation will not provide this without prior assurance that funding is available for long term supported employment supports once placement, training and stabilization are complete. Some individuals may not be receiving a waiver service at the time of entrance to SEP and it can last up to 18 months before transition to Extended Services. The reserve capacity assures continuity of SEP services long term for individuals who are not enrolled in the waiver at initiation of SEP.

**Describe how the amount of reserved capacity was determined:**

The case management information system was queried to determine how many individuals are currently receiving SEP through Vocational Rehabilitation and would likely transition to Extended Services during Year 1 of the waiver.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 5 |
| Year 2 | 5 |
| Year 3 | 5 |
| Year 4 (renewal only) | 5 |
| Year 5 (renewal only) | 5 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Emergency

**Purpose** *(describe):*

The State reserves slots for emergency situations in which potentially eligible consumers are in need of supports to ensure health and welfare.

A person is considered to have emergency needs when: The individual is at significant, imminent risk of serious harm because the primary caregiver(s)/support system is/are not able to provide the level of support necessary to meet the person's basic needs; and/or the individual requires protection from confirmed abuse, neglect, or exploitation; and whose needs can be addressed through licensed DD services.

Reserved slots will be managed through the DD Division.

**Describe how the amount of reserved capacity was determined:**

Based on current enrollment, trend data from the State Review Team, ND Developmental Center, ND State Hospital, and Regional DD Program Administrators.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 50 |
| Year 2 | 50 |
| Year 3 | 50 |
| Year 4 (renewal only) | 50 |
| Year 5 (renewal only) | 50 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** *(provide a title or short description to use for lookup):*

Early Intervention

**Purpose** *(describe):*

The State will reserve slots for children birth to three years of age to provide intervention in a timely manner for young children who will benefit from early intervention services. Reserved slots will be assigned based on eligibility date once general waiver slots have been reached.

**Describe how the amount of reserved capacity was determined:**

Based on current waiver enrollment and trend data.

**The capacity that the State reserves in each waiver year is specified in the following table:**

| Waiver Year | Capacity Reserved |
|---|---|
| Year 1 | 135 |
| Year 2 | 135 |
| Year 3 | 135 |
| Year 4 (renewal only) | 135 |
| Year 5 (renewal only) | 135 |

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (•) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one*:

- (•) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Until the waiver cap is reached, minus the reserved slots, the eligible consumers will be enrolled on a first-come, first-serve basis. When the cap is reached, a waiting list based on time of application will be used. If the reserved capacity for 'Emergency' has been exhausted, applicants whose situation meets the definition for 'Emergency' will be given priority on the waiting list.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

**Answers provided in Appendix B-3-d indicate that you do not need to complete this section.**

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a.**

1. **State Classification.** The State is a *(select one)*:
   - ( ) **§1634 State**
   - ( ) **SSI Criteria State**
   - (•) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

***Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- [x] **Low income families with children as provided in §1931 of the Act**
- [ ] **SSI recipients**

- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one*:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [x] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

Individuals eligible under sections 1902(a)(10)(A)(i)(I),(IV),(VI),and (VII); section 1902(a)(10)(C)(ii)(I); section 1902 (a)(52)of the SSA; 42 CFR 435.308 and .310; and all other optional eligibility groups covered under the ND State Plan.

***Special home and community-based waiver group under 42 CFR §435.217)*** *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ◉ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ○ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

- ○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- ○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies*:

- [ ] **A special income level equal to:**

*Select one*:

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

- **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- **Aged and disabled individuals who have income at:**

*Select one*:

- **100% of FPL**
- **% of FPL, which is lower than 100%.**

Specify percentage amount:

- **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.*

**a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

**b. Regular Post-Eligibility Treatment of Income: SSI State.**

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.**

# Appendix B: Participant Access and Eligibility

## B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

**ii. Frequency of services.** The State requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

Minimum frequency: Quarterly

Individuals are screened to the ICF/MR level of care when it is expected that the person will need and receive a waiver service within 30 days and that waiver services will be furnished at least quarterly. It is expected that non-intermittent services will be delivered monthly. Occasionally an individual who is receiving an intermittent service such as In-Home Support or Transportation, may not be delivered during a particular month. For example, during a particular month a scheduling conflict may occur for the family, there is no paid caregiver available and therefore no waiver service is received. The DD Program Manager will monitor the use of services as part of the quarterly audit. If, based on audit, the individual has not received a monthly service the DD Program Manager will initiate a monthly contact with the individual or legal decision maker to ensure health and safety of the waiver recipient and will determine if the service continues to be appropriate and whether there continues to be a reasonable expectation that the service will be delivered monthly. If the participant is found not to be utilizing the waiver services, a re-evaluation of level of care will be conducted to reassess the need for waiver services.

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ◉ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- ○ **Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DD Program Managers at the Regional Human Service Centers will perform the initial evaluation of level of care for waiver applicants. The minimum qualifications for DD Program Managers require that they meet the criteria for Qualified Mental Retardation Professional (QMRP).

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Individuals that may be eligible for ICF/MR level of care include individuals with a diagnosis of mental retardation as defined in ND Administrative Code 75-04-06 or persons with related conditions as defined in 42 CFR 435.1009 with accompanying cognitive limitations, and who are eligible for Medicaid. An evaluation instrument is used in North Dakota to determine whether an individual meets the minimum criteria for ICF/MR level of care. The evaluation instrument is a component of an automated system and is used to assess individual strengths and needs and to assist in the determination of eligibility as well as evaluation of level of care. The individual assessment describes the DSM IV diagnoses on Axis I, II and III and the level of supports needed by an individual in the following areas: residential, day services, motor skills, independent living, social, cognitive, communication, adaptive skills, behavior, medical and legal. Once the evaluation is completed, an indicator is electronically derived from the scores in ASSIST that determines whether an individual meets the basic criteria for the ICF/MR level of care. The HCBS indicator, in conjunction with the professional judgment of the Program Manager, will serve as the basis as to whether the individual will be screened for waiver services.
If the HCBS indicator is “N” (no), the individual cannot be screened to the ICF/MR Level of Care. If the HCBS indicator is “Y” (yes), the individual may be screened. If the HCBS indicator is “P” (professional judgment), the DD Program Manager will apply professional judgment, utilizing the Guidelines for ICF/MR Level of Care Screenings (DDD-PI-090) to determine if the individual can be screened.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The DD Program Manager will obtain psychological, medical, educational and other relevant assessments and information as part of the application and intake process to the Regional Human Service Center. The DD Program Manager will schedule an interview/visit with the individual and/or legal decision maker, to assess the individual’s needs and desired outcomes. During the initial visit(s), the DD Program Manager will complete the evaluation instrument. The evaluation results are entered into the automated system (ASSIST) to determine if the minimum criteria are met for level of care. If the finding is affirmative, the DD Program Manager will complete the Case Action Form in ASSIST to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the individual and/or legal decision maker will be notified of their right to appeal the adverse decision. The level of care criteria used for the re-evaluation is the same criteria applied for the initial level of care. The DD Program Manager will complete the PAR based on the most current assessment information available and an interview with the individual and/or those who know the person best. The re-evaluation does not require an updated psychological assessment if the diagnosis has been confirmed, unless it is determined that a new assessment will be beneficial or is needed The results are entered into the automated system (ASSIST) to determine if the minimum criteria is met for level of care and continued enrollment in waiver services. If the finding is affirmative, the DD Program Manager will complete the Case Action Form in ASSIST to document the level of care for the MMIS payment system. If it is determined the individual does not meet the level of care, the individual and/or legal decision maker will be notified of their right to appeal the adverse decision.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ( ) **Every three months**
- ( ) **Every six months**
- (●) **Every twelve months**
- ( ) **Other schedule**

*Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  *Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify):*

When the evaluation results are completed and activated in ASSIST a system generated Alert due date is calculated to plus one year minus one day to ensure that the re-evaluation of level of care is performed on a timely basis. In addition, when the Case Action Form is completed and activated in ASSIST a system generated Alert is created with an Alert Due Date equal to the Active Case Action Termination Date or end date, minus 2 months to ensure that the re-evaluation of level of care is performed on a timely basis and entered into MMIS. The Alerts are system-deleted when a new Alert is created. The DD Program Manager and their supervisors have the ability to review all alerts by manager assigned caseload, due date, type of alert, individual case.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Documentation of the Level of Care Evaluations/Reevaluations are maintained electronically for each individual for a minimum of 3 years+ in the ASSIST application which can be accessed at the Regional Human Service Center or DD Division. The MMIS system also maintains a record/history of level of cre determinations.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
   i. **Sub-Assurances:**

      a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

         **Performance Measures**

         *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

         *For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

         **Performance Measure:**
         **(B-1) The initial level of care determination for all applicants will be completed within 45 days of referral.**

         **Data Source** (Select one):
         **Other**
         If 'Other' is selected, specify:
         **Query of data from Assist database.**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(B-2) The level of care will be re-evaluated at least annually for all waiver enrolled participants.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Queries from Assist Data Base.**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(B-3) Initial and annual reevaluations will be completed accurately and consistently for all waiver participants.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:
**Qualitative reviews involving individual case reviews conducted biennually for each regional Human Service Center to assess accuracy and consistency.**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group: Based on age, services, and DD Program Manager |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | |
|---|---|
| | ☑ **Other**<br>Specify:<br>Biennually |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Biennually |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The DD Division will review claims data annually to analyze patterns related to Level of Care issues.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Patterns of errors will be analyzed to determine if they are the result of individual, region, or systemic issues. The Regional DD Program Administrators will address individual issues and Regional training needs. The DD Division is available to assist Regional DD Program Administrators, as well as addressing systemic issues.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| | |

**c. Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- **No**
- **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

***Freedom of Choice.*** *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

*i. informed of any feasible alternatives under the waiver; and*
*ii. given the choice of either institutional or home and community-based services.*

**a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals eligible for the waiver will be provided with a choice of institutional or HCBS services, feasible alternatives under available waivers will be explained by the DD Program Manager and a description of services and list of all available DD Licensed Providers will be provided to the individual and/or legal representative. The individual choice will be documented on the Individual Service Plan (ISP). This information will be provided at the time of waiver eligibility determination and annually thereafter.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The signed Person Centered Service Plan is maintained in the consumer's file at the Regional Human Service Center for more than three years.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
When a consumer and/or their legally responsible caregiver is unable to independently communicate with the DD Division staff, their DD Program Manager or Administrator, or the fiscal agent, the services of an interpreter will be arranged. Written material may also be modified for non-English speaking consumers. The North Dakota Department of Human Services has a Limited English Proficiency Implementation Plan to assist staff in communicating with all consumers.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

| Service Type | Service | | |
|---|---|---|---|
| Statutory Service | Adult Day Health | | |
| Statutory Service | Day Habilitation | | |
| Statutory Service | Extended Services | | |
| Statutory Service | Homemaker | | |
| Statutory Service | Residential Habilitation | | |
| Extended State Plan Service | Extended Home Health Care | | |
| Other Service | Adult Family Foster Care | | |
| Other Service | Behavioral Consultation | | |
| Other Service | Environmental Supports/Modifications | | |
| Other Service | Equipment and Supplies | | |
| Other Service | Family Care Option | | |
| Other Service | In-Home Supports | | |
| Other Service | Infant Development | | |
| Other Service | Parenting Support | | |
| Other Service | Transportation Costs for Financially Responsible Caregiver | | |

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

**Alternate Service Title (if any):**

**Service Definition** *(Scope):*

Services furnished 3 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting of a health care facility or community- based setting, encompassing either health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the Person Centered Plan may be furnished as a component of this service if the provider is licensed according to NDCC 43-26.1, 43-40, and/or 43-37 as applicable to the therapies provided.

The cost of transportation from the individual's residence to the Adult Day Health program is included in the rate paid to providers of Adult Day Health services if the provider elects to include transportation in the rate.

This service is limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition.

This service shall not be furnished/billed at the same time of day as Extended Services, or Family Support Services, Adult Day Health, Homemaker, or services such as Personal Care or other services under the State Plan Medicaid services that work directly with the person.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Adult Day Health, Day Supports and hours of employment in Extended Services combined cannot exceed 40 per week. Adult Day Health cannot be billed at the same time as Day Supports, Extended Services, or Family Support Services.

Non medical transportation may be included as a part of this service and is included in the rate if the provider offers it. Physical, occupational and speech therapies may be provided and included in the rate if the provider is licensed to provide that service.

Transportation for Adult Day Care can only be included in the rate of a provider that elects to do so and cannot be discretely billed or duplicated by State Plan Medicaid services or with other transportation provided in this service. Medical transportation under the State Plan must be prior authorized and is not authorized for transport to Adult Day Care.

Note: Allowable service combinations in Person Centered Service Plans are included in licensure case reviews for Developmental Disabilities Program Management. Transportation to Adult Day Care is not allowable as an allowable service.

The service unit for Adult Day Health is 1/2 day (4 hours) of service. A unit may be billed if at least 3 hours of service have been provided. If less than 3 hours are provided, a unit cannot be billed. Services are a minimum of 3 hours per day through a maximum of 10 hours per day, on a regularly scheduled basis, for one or more days per week. Providers are required to maintain service and census records subject to audit to verify that at least 3 hours of service were provided to justify billing a unit.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Adult Day Care provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Adult Day Health**

**Provider Category:**
Agency
**Provider Type:**
Adult Day Care provider
**Provider Qualifications**
**License** *(specify):*
Agency only - N.D.C.C. 23-16; N.D.A.C. 33-07-01; 33-07-03.1; N.D.A.C. 33-03-24.1-10
**Certificate** *(specify):*

**Other Standard** *(specify):*
Enrolled Qualified Service Provider (QSP) N.D.A.C. 75-03-23-07
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
ND Medical Services Division
**Frequency of Verification:**
Initial/Re-enrollment every two years, and/or upon notification of provider status change.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

**Service Definition** *(Scope):*

Day Supports provide assistance to the participant with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day Supports are furnished in a non-residential setting, separate from the home or facility where the participant resides, but may be furnished in the individual's home during traditional Day Supports schedules if the individual(s)' needs preclude traveling from the home on a regular basis. Day Supports focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the Person Centered Support Plan. Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the Person Centered Support Plan and the service originates from the licensed day program. This service is limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition. This service may not duplicate services provided under Extended Services, Adult Day Health, or Residential Habilitation.

Rates for Day Supports may include transportation costs to access program related activities in the community. Transportation does not include travel between the individual's home and the Day Supports program site. Any transportation provided to an individual as a part of the rate is not billable as a discrete service and cannot duplicate transportation provided under any other service in this waiver.

This service shall not be furnished/billed at the same time of day as Extended Services, or Family Support Services, Adult Day Health, Homemaker, or services such as Personal Care or other services under the State Plan Medicaid services that work directly with the person.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

An individual may be enrolled concurrently in Day Supports and Extended Services subject to limitations in Section III.C.4 of DDD-PI-088. However, billing for services may not be duplicated for a time period (i.e. billed for both for 1 to 5 pm on April 1, 2009). Adult Day Health, Day Supports and hours of employment in Extended Services combined cannot exceed 40 per week.

This service will not be authorized for or payment made for individuals who are eligible for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition.

**Service Delivery Method** *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Licensed DD Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Day Habilitation**

**Provider Category:**
Agency
**Provider Type:**
Licensed DD Provider
**Provider Qualifications**
**License** *(specify):*
Licensed to provide Day Habilitation according to NDAC 75-04-01.
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DD Division
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Statutory Service
**Service:**
Supported Employment
**Alternate Service Title (if any):**
Extended Services
**Service Definition** *(Scope):*
Extended Services is ongoing support for an individual in supported employment upon completion of training and stabilization in employment; providing on or off the job employment-related support for individuals needing intervention to assist them in maintaining employment. This may include job development, replacement in the event of job loss, and, for provider managed services, must include a minimum of two onsite job skills training contacts per month and other support services as needed to maintain employment. It may also mean providing other support services at or away from the worksite. If offsite monitoring is appropriate, it must, at a minimum, consist of two meetings with the individual and one contact with the employer each month.

Supported employment/ Extended Services does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA.

The provider managed services are limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an inter-departmental plan of transition.

Provider managed Extended Services may not be billed at the same time as Day Supports, State Plan Personal Care Services, family supports, Adult Day Health, or Homemaker services.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
An individual may receive a combination of service types like Day Supports, Extended Services and Adult Day Health, provided that they do not exceed 40 hours per week and may not be billed at the same time according to subject limitations in Section III.C.4 of DDD-PI-088.

Transportation costs for individuals from their residence to their workplace may be included in the service rate when an individual needs it as a support intervention necessary for the individual to maintain employment. It is not allowed as a substitute for personal, public or generic transportation, is not billable as a discrete service, and cannot duplicate any transportation through the State Plan or

waiver transportation service. If transportation is to be included in the rate, the Regional Developmental Disabilities Program Administrator must certify the number of individuals for whom transportation is necessary as part of intervention to successfully support continued employment.

For participant-directed services, transportation is not included as part of this support. In addition, intervention will be determined according to the Extended Services Operation Manual.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Licensed Extended Services Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Extended Services**

**Provider Category:**
Agency
**Provider Type:**
Licensed Extended Services Provider
**Provider Qualifications**

**License** *(specify):*
Developmental Disabilities service provider licensed to provide Extended Services per ND Administrative Code 75-04-01.

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Developmental Disabilities Division
**Frequency of Verification:**
Annual license renewal

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

**Service Definition** *(Scope):*

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is unable to manage the home and care for him or herself. Homemakers shall meet such standards of education and training as established by the State for the provision of these activities.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The cost of this service is limited to a maximum monthly cap established by legislative appropriation. This amount allows for approximately 12 hours of service per month at the highest provider rate allowed. If a participant has a need for cleaning of an unusual nature, DD Division prior approval is required to exceed the cap.

Note: The service rate is capped by legislative appropriation. The cap is different for agency providers than individual providers as agency providers are allowed an administrative reimbursement. Providers may choose to use a rate that is less than the cap.

Homemaker services cannot be provided to an individual living with a legally responsible caregiver. Homemaker services cannot be provided along with Residential Habilitation or Adult Foster Care.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Qualified Service Provider |
| Agency | Qualified Service Provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Homemaker**

**Provider Category:**

Individual

**Provider Type:**

Qualified Service Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Enrolled as a QSP according to NDAC 75-03-23-07 and demonstrates competencies in homemaker standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
ND Dept. of Human Services Medical Services Division

**Frequency of Verification:**
Re-enrollment every two years and/or upon notification of provider status change.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Homemaker**

**Provider Category:**
Agency

**Provider Type:**
Qualified Service Provider

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Enrolled QSP per N.D.A.C. 75-03-23-07

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
ND Dept. of Human Services Medical Services Division

**Frequency of Verification:**
Re-enrollment every two years and/or upon notification of provider status change.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**
Statutory Service

**Service:**
Residential Habilitation

**Alternate Service Title (if any):**

**Service Definition** *(Scope):*
Residential Habilitation consists of an integrated array of individually designed training activities, assistance and supervision. Residential Habilitation is provided in licensed/unlicensed community residential settings that include Adult Family Foster Care or Family Foster Care licensed homes, group homes and homes leased, owned or controlled by individuals.

Residential Habilitation includes:

(1) Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to reside as independently as possible in the community.

(2) Assistance in activities of daily living when the participant is dependent on others to ensure health and safety.

(3) Assistance, support, supervision and monitoring that allow the individual to participate in home life or community activities.

Residential Habilitation is provided in the following settings:

"Congregate care" means a specialized program to serve elderly individuals with developmental disabilities whose health and medical conditions are stable and do not require continued nursing and medical care, and are served within a community group-living arrangement.

"Minimally supervised living arrangements" means either:
a. A group home with an available client adviser; or
b. A community complex that provides self-contained rented units with an available client adviser.

"Transitional Community Living Facility" means a residence for clients with individualized programs consisting of social, community integration, and daily living skills development preliminary to entry into less restrictive settings.

"Supported Living Arrangement" means a program providing a variety of types of living arrangements that enable individuals with disabilities to have choice and options comparable to those available to the general population. Clients entering this service shall have the effects of any skill deficits subject to mitigation by the provision of individualized training and follow-along services.

"Individualized Supported Living Arrangements" means a residential support services option in which services are contracted for a client based on individualized needs resulting in an individualized rate setting process and are provided to a client in a residence rented or owned by the client.

"Family Care Option III" is an individual support provided in an apartment for adolescents or young adults who are unable to live in a family home setting. In exceptional circumstances this service may support younger children in order to maintain them in their home community. This service also focuses on close communication and coordination with families and the school system during the transition period.

4)Residential Habilitation may include professional services not available as a state plan service, as needed to meet health and welfare needs of recipients. This may include behavior management, nursing, or dietetics. Behavior management services do not duplicate state plan services as services include ongoing development, application, and monitoring of behavior management plans for individuals and training of direct service staff. Psychology services reimbursable under the Medicaid state plan include only evaluation and psychotherapy by a licensed clinical psychologist. Behavior management under Behavior Consultation services in the waiver is not available to Residential Habilitation recipients as that service is limited to individuals living in a family home. Dietician services are not state plan services. Staff employed or contracted by provider agencies must meet licensure or certification appropriate to their scope of practice according to North Dakota Century Code Title 43. Professional services included as part of a rate are not billable as a discrete service.

Exclusions

Participants who receive Residential Habilitation may not receive Family Support Services In-Home Support, Parenting Support, State Plan Personal Care Services, Adult Family Foster Care, Behavior Consultation or Homemaker Services. Payment for Residential Habilitation does not include room and board, or the cost of facility maintenance and upkeep.
This service is not available at the same time of day as Day Supports, Extended Services or one of the State Plan Medicaid services that works directly with the person.

Residential Habilitation rates do not include client transportation.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**
**Service Name: Residential Habilitation**

**Provider Category:**
Agency
**Provider Type:**

**Provider Qualifications**
**License** *(specify):*
Licensed according to NDAC 75-04-01.
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
ND Dept. of Human Services Developmental Disabilities Division
**Frequency of Verification:**
Annual license renewals

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Extended State Plan Service
**Service Title:**
Extended Home Health Care

**Service Definition** *(Scope):*
Home Health Care is an Extended State Plan Service which is available when an eligible participant living with a primary caregiver has maximized the amount of service available under the State Plan. The Person Centered Plan must address health and safety issues and support Home Health Care as a service necessary in order for the eligible participant to remain in a family home setting in their community. This service is not available to partipants receiving Residential Habilitation.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Extended State Plan Service**
**Service Name: Extended Home Health Care**

**Provider Category:**
Agency
**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
Certified as a Home Health Care provider under Medicare or a DD Licensed Provider of Family Support Services
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Medical Services and DD Division
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Family Foster Care

**Service Definition** *(Scope):*

Adult Family Foster Care is a licensed home where residential support services are provided in a family home atmosphere with not more than 4 people. Services include preparation of meals, general housekeeping, medication assistance, personal care assistance, and assistance to access the community and social and leisure activities.

Room and board and transportation costs are not included in payments. AFFC may not be provided in conjunction with Residential Habilitation, Family Support Services-In-Home Supports, FSS Family Care Option, FSS Family Care Option III, Homemaker Services, FSS Parenting Support, Transportation, Materials and Supplies, or with Medicaid State Plan Personal Care services.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The cost of this service is limited to a maximum monthly cap set by the Department or through legislative action. If a participant requires personal care or supervision supports for health and safety in excess of the limit, DD Division prior approval is required. This limit may be increased as determined by legislative action.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Licensed AFFC provider |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Adult Family Foster Care**

**Provider Category:**

Individual

**Provider Type:**

Licensed AFFC provider

**Provider Qualifications**

**License** *(specify):*

Licensed according to NDAC 75-03-21.

**Certificate** *(specify):*

**Other Standard** *(specify):*

Enrolled as a Qualified Service Provider according to NDAC 75-03-23-07.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

ND Department of Human Services Aging Services and Medical Services Divisions.

**Frequency of Verification:**

Every two years.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Behavioral Consultation

**Service Definition** *(Scope):*

Behavior Consultation Services provide expertise, training and technical assistance to assist primary caregivers, in-home support staff and other natural supports. Activities covered are: (1) Observing the participant to determine needs; (2) Assessing any current interventions for effectiveness; (3) Developing a written intervention plan; (4) Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports; (5)Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies; (6)Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes; (7)Training and technical assistance to relevant persons to instruct them on the implementation of the participant's intervention plan; and/or (8)Participating in team meetings. Behavior Consultation excludes services provided through the Medicaid State Plan or the IEP. This service is only available for individuals living in a family home.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to $5200 per State Fiscal Year.

The service is only available to individuals living in a family home and is not available to individuals receiving Residential Habilitation Services.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Behavioral Consultation**

**Provider Category:**
Individual
**Provider Type:**
Individual
**Provider Qualifications**
**License** *(specify):*
Four year degree that included course work in positive behavior modification
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Fiscal Agent
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Behavioral Consultation**

**Provider Category:**
Agency
**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
Staff with 4 year degree that included course work in positive behavior modification
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Fiscal Agent
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental Supports/Modifications

**Service Definition** *(Scope):*

Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned or rented by the participant or their family (natural, adoptive, or foster family). Only items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant.

Items that are not of direct or remedial benefit to the participant are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired.

Covered Modifications are:

(1) Ramps and Portable Ramps
(2) Grab Bars
(3) Handrails
(4) Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home
(5) Porch stair lifts
(6) Modifications and/or additions to bathroom facilities
a) Roll in shower
b) Sink modifications
c) Bathtub modifications/grab bars
d) Toilet modifications
e) Water faucet controls
(7) Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
(8) Specialized accessibility/safety adaptations/additions
a) Electrical wiring
b) Fire/safety adaptations, including alarms
c) Shatterproof windows
d) Floor coverings for ease of ambulation
e) Modifications to meet egress regulations
f) Automatic door openers/doorbells
g) Voice activated, light activated, motor activated electronic devices to control the participant's home environment
h) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
i) Stationary built-in therapeutic tables

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered. Equipment or supplies purchased for exclusive use at the school/home school are not covered. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

For individuals living in a private residence who are supported by a licensed residential provider, environmental modifications/supports will be authorized only if resulting in a cost effective reduction of staff support.

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, and maintenance of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:
(1) Door modifications
(2) Installation of raised roof or related alterations to existing raised roof system to increase head clearance
(3) Lifting devices
(4) Devices for securing wheelchairs or scooters
(5) Handrails and grab bars
(6) Seating modifications
(7) Lowering of the floor of the vehicle
(8) Safety/security modification

The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered.

To receive this service you must be living in a family home.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
The amount of service will not exceed $20,000 for the duration of the waiver. The authorization database will track the amount authorized and utilized to prevent over- expenditure.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Supports/Modifications**

**Provider Category:**
Individual
**Provider Type:**
Individual
**Provider Qualifications**
**License** *(specify):*
None
**Certificate** *(specify):*
None
**Other Standard** *(specify):*
Consumer and/or legal decision maker along with Person Centered Service Plan team members will identify the appropriate Environmental Supports and Modifications within the Person Centered Service Plan. In addition to identifying the appropriate environmental supports or modifications, the Person Centered Service Plan Team will determine if the adaptations can be made by family members, i.e. a father building a ramp according to ADA specifications. In those specific circumstances the consumer and/or legal decision maker will obtain the specified material from an individual who is enrolled as a vendor with the Fiscal Agent.

The Person Centered Planning Team will consider the technical and safety requirements of specific environmental

modifications when they consider recommending individual vs. agency provider specifications, i.e. installation of a van lift would only be authorized through a vendor authorized by the manufacturer. If an individual is contracted to perform the modifications, that individual may not be living in the same home as the eligible consumer.

Consumer and/or legal decision maker along with Person Centered Service Plan team members will identify the appropiate Environmental Supports and Modifications within the Person Centered Plan. The consumer and/or legal decision maker will obtain the material from a vendor who is enrolled with the Fiscal Agent.
As applicable: building permits, Bonded and Licensed to practice profession, Enrolled with Secretary of State, and in good standing with Workforce Safety. American's with Disabilities Act guidelines will be followed.

The vendor must provide the item approved in Person Centered Plan, or recommended by a licensed professional,and selected by individual or legal decision maker as cost effective.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The DD Division will monitor that Person Centered Service Plans identify the Environmental Supports and Modifications to be obtained, as well as, monitor the vendor enrollment process of the Fiscal Agent.

**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Environmental Supports/Modifications**

**Provider Category:**
Agency

**Provider Type:**
Agency

**Provider Qualifications**

**License** *(specify):*
None

**Certificate** *(specify):*
None

**Other Standard** *(specify):*
Consumer and/or legal decision maker along with Person Centered Service Plan team members will identify the appropriate Environmental Supports and Modifications within the Person Centered Plan. The consumer and/or legal decision maker will obtain the material from a vendor who is enrolled with the Fiscal Agent.
As applicable: building permits, Bonded and Licensed to practice profession, Enrolled with Secretary of State, and in good standing with Workforce Safety. American's with Disabilities Act guidelines will be followed.

The vendor must provide the item approved in Person Centered Plan, or recommended by a licensed professional,and selected by individual or legal decision maker as cost effective.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
The DD Division will monitor that Person Centered Service Plan identify the Environmental Supports and Modifications to be obtained, as well as monitor the vendor enrollment process of the Fiscal Agent.

**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Equipment and Supplies

**Service Definition** *(Scope):*

Funds may be accessed to meet the excess disability related expenses associated with maintaining an eligible consumer in their primary caregiver's home. Equipment and Supplies enable an individual living with a primary caregiver, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan:

Examples of Equipment and Supplies not included in the Medicaid State Plan include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; 3) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 4) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; 5) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 6) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants; and (e) Personal Emergency Response System is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep and maintenance of devices/systems are provided.

Items reimbursed with waiver funds are in addition to any equipment and supplies furnished under the State plan and exclude those items that are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

To receive this service, eligible consumers must be living in a family home.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to $20,000 per person for the duration of waiver. The equipment and supplies must not be attainable through other informal or formal resources and can only include the purchasing of items that relate directly to the client's care needs. A written recommendation by an appropriate professional and 3 separate trial of use, when appropriate, must be obtained to ensure that the equipment will meet the needs of the individual prior to consideration for approval. Pre-approval from the Department is required before this service can be authorized. The authorization database will track the amount authorized and utilized to prevent over expenditure.

For generic technical devices (iPads, computers, etc.) that can be used by other family members, 50% of the base model, case, and repair will be covered and up to $250 worth of applications, as appropriate for the individual's disability.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Vendor |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Equipment and Supplies**

**Provider Category:**
Agency
**Provider Type:**
Vendor
**Provider Qualifications**
**License** *(specify):*
None
**Certificate** *(specify):*
None
**Other Standard** *(specify):*
Consumer and/or legal decision maker along with Person Centered Planning team members will identify the appropiate equipment and supplies within the Person Centered Plan. The consumer and/or legal decision maker will obtain the equipment and supplies from a provider who is enrolled with the Fiscal Agent. The vendor must provide the item approved in Person Centered Plan and selected by individual or legal decision maker as cost effective. For durable equipment not covered in state plan the vendor must offer the specific item recommended by a licensed professional.
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
The DD Division will monitor that Person Centered Plans identify the equipment and supplies to be obtained, as well as monitor the vendor enrollment process of the Fiscal Agent.
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Family Care Option
**Service Definition** *(Scope):*
Family Care Option will be provided on a part-time or full-time basis in a family home that meets the standards of a licensed family or adult family foster care home. This service focuses on close communication and coordination with families and the school system during the transition period. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in

community experiences and activities.

This service is provided out-of-the child's home, in another family home meeting the licensing standards for Family or Adult Foster Care. Family Care Option may be appropriate for eligible waiver consumers less than 21 years of age who cannot remain in their natural family home on a full-time basis.

Family Care Option is available if the eligible waiver consumer is receiving the proper parental care and education necessary for the consumer's physical, mental or emotional health as reference in North Dakota Century Code 27-20-02(5) and is not considered boarding care according to the definition of the North Dakota Department of Public instruction. Family Care Option is not available in group residential settings. Family Care Option is also not available when residential group home supports, Family Care Option III, or Adult Family Foster Care are authorized. Additionally, the eligible waiver consumer must continue to receive Special Education funded supports through an Individualized Education Plan in order to receive Family Care Option supports.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Individuals receiving services from the Family Care Option MUST have an active IEP (Individual Education Plan). This service will not be delivered in group residential settings.

**Service Delivery Method** *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Family Care Option**

**Provider Category:**
Agency
**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
Licensed according to NDAC 75-04-01.
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DD Division
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

In-Home Supports

**Service Definition** *(Scope):*

In-Home Supports (IHS) enable an individual with a disability, who so desires, to remain in and be supported in their family home and community. IHS is intended to support both the family member with a disability and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible client must be living with their primary caregiver. IHS benefits the eligible client by supporting their primary caregiver in meeting the needs of the eligible client within their daily and community routines. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in community experiences and activities.

IHS is available while the primary care is present or absent due to work or school. IHS is also available to provide the primary caregiver temporary relief from the demands of supporting their family member with a disability (Respite). The eligible client will be supported in the home in which they live or in the home of the relief care provider if the home is approved by the legal decision maker. IHS may also be provided on a part time or full time basis in the home of a relief care provider if the home meets the standards of a licensed foster care home.

Individuals providing IHS may not live in the same home as the eligible individual.

IHS supports will not be delivered in group residential settings.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

In addition to assisting the primary caregiver in meeting the needs of the eligible consumer, IHS is available to provide the primary caregiver temporary relief (respite) from the demands of supporting their family member with a disability not to exceed 20 hours per month.

An eligible individual age 11 years of age or younger must not be able to access child care in a typical setting – either due to medical or behavioral issues. Legally, all eligible individual under 12 years of age require a substitute caregiver when the parents are not available. The usual cost for full time child care (during a parent's school or work hours) continues to be the financial responsibility of the parent and any IHS hours are offset/pro-rated by the amount determined by the Department. The amount will be reviewed annually.

For eligible individual 12 years of age and older IHS services may be appropriate to authorize if other informal supports are not available to provide general supervision.

Total hours of support will be limited to 300 per month per individual unless an exception is approved by the Developmental Disability Division as preventing imminent institutionalization.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**

☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: In-Home Supports**

**Provider Category:**
Individual
**Provider Type:**
Individual
**Provider Qualifications**
**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
As required by the Person Centered Service Plan or IFSP
**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
Fiscal Agent
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: In-Home Supports**

**Provider Category:**
Agency
**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
Licensed according to NDAC 75-04-01.
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DD Division
**Frequency of Verification:**

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Infant Development

**Service Definition** *(Scope):*

Infant Development is a home-based, family focused service that provides information, support and training to assist families in maximizing their child's development. Early intervention professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. Infant Development serves children birth to 3 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction.

The Infant Development service delivery model is based on research showing that infants and toddlers do not learn in massed trials, but through natural learning opportunities that occur throughout the day.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The current minimum requirement in order to receive the daily rate for the month is one home visit per month. A home visit involves at least one hour of direct face to face interaction with the family. The Infant Development budgeting process was developed from a residential model and needs to be changed as addressed in the Quality Improvement section of this Appendix.

Note: The daily Infant Development rate is a retrospective cost based rate and upon audit settlement, reimbursement is limited to actual costs only.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Infant Development**

**Provider Category:**

Agency

**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
Licensed according to NDAC 75-04-01.
**Certificate** *(specify):*

**Other Standard** *(specify):*
Infant Development programs must provide services according to the prescribed delivery model and cannot offer other models, including direct therapy to infants and toddlers.

The prescribed service delivery model is based on research showing that infants and toddlers do not learn in massed trials, but through natural learning opportunities that occur throughout the day. Infant Development services are a home-based, family focused service that provides information, support and training to assist families in maximizing their child's development. Early intervention professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines.

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DD Division
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Parenting Support
**Service Definition** *(Scope):*
Parenting Support assists eligible consumers who are or will be parents in developing appropriate parenting skills. Individual and group training and support will be available. Parents will receive training that is individualized and focused on the health and welfare and developmental needs of their child. Close coordination will be maintained with informal supports and other formal supports. This service is not available if Residential Habilitation is authorized. If the eligible consumer (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training, but group training and support activities will be provided.
**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**
Parenting Support is limited to an average of four hours of individualized child-focused direct training per week during a quarter. Support is available from the first trimester until the eligible participant's child is 18 years of age.
Parenting Support is different from family support programs as the eligible individual is the parent. In family support programs the eligible individual is the child.

**Service Delivery Method** *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Agency | Agency |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Parenting Support**

**Provider Category:**
Agency
**Provider Type:**
Agency
**Provider Qualifications**
**License** *(specify):*
According to NDAC 75-04-01. Licensed to provide Family Support Services or Infant Development
**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**
**Entity Responsible for Verification:**
DD Division
**Frequency of Verification:**
Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
**Service Type:**
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
**Service Title:**
Transportation Costs for Financially Responsible Caregiver
**Service Definition** *(Scope):*
Funds may be accessed to meet the excess transportation costs related to the participant's disability. Transportation Costs for Financially Responsible Caregivers enable a family member with a disability, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan: transportation expenses such as mileage, lodging, etc. incurred by family members related to accessing supports identified in the Person Centered Plan, lodging for the eligible client and/or accompanying caregiver will only be allowed when medically necessary or cost effective, the reimbursed amount will not exceed allowed state rates which for out of state

travel are based on Federal Guidelines. In addition, lodging will not be reimbursed without a receipt.

All associated costs (i.e. mileage,lodging, meals) must be authorized before reimbursement for transportation can occur. The authorization is a part of the Person Centered Service Planning process. The authorization is also approved by the DD Division.

Financially responsible caregivers (parents of minor children) cannot become Medicaid Transportation Providers through the Medicaid State Plan. To receive this waiver service, eligible consumers must be living in a family home with their financially responsible caregiver.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Limited to $5,200 per State Fiscal Year. Mileage included in individual authorization will not exceed map miles between individuals dwelling and point of service being accessed.

A table has been developed with Department of Human Services Medical Services Division to clarify when transportation as a waiver service can be accessed and when transportation is reimbursed through the Medicaid State Plan. The table has been distributed to County and Program Management staff. Transportation reimbursement will not not duplicate other transportation that may be provided through other waiver services or the State Plan.

**Service Delivery Method** *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

**Specify whether the service may be provided by** *(check each that applies)***:**

- [x] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

**Provider Specifications:**

| Provider Category | Provider Type Title |
|---|---|
| Individual | Individual |

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**
**Service Name: Transportation Costs for Financially Responsible Caregiver**

**Provider Category:**
Individual
**Provider Type:**
Individual
**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*
Vaild Driver's License and required insurance

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**
Fiscal Agent will verify that lodging, meals and mileage does not exceed the amount of the submitted receipts and the total requested does not exceed the amount authorized by the Program Manager.

**Frequency of Verification:**
Annually review of the drivers license and insurance. Fiscal Agent will verify expenditures and provider qualifications per contract requirements.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

DD Program Management through the Regional Human Service Centers which are under the umbrella of the Department of Human Services.

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

As provided by NDAC 75-04-05 and DDD-PI-086, criminal background checks must be conducted on all prospective employees of licensed DD provider agencies who may have direct access to individuals served. This includes direct care positions, administrative positions, and other support positions that have contact with individuals served. When prospective employees have lived in North Dakota for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.
The DD Division reviews any record of a criminal conviction of an applicant to determine if according to NDCC 12.1-33-02.1 the individual is eligible to be considered for employment by a licensed DD provider.
Upon annual application for license renewal, the applicant agency must submit a listing of each current employee with a criminal record and date and nature of the offense. Those listings are checked against reports to the Division to determine if in fact the provider had submitted the record for review by the Division prior to assuming duties in direct contact with individuals served.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

DDD-PI-086 also requires that providers conduct a check of the Child Abuse and Neglect Registry for each employee hired. The Child Abuse and Neglect Registry is maintained by the ND Dept. of Human Services Children and Family Services Division. An abuse registry is not maintained specifically for providers of waiver services.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

| Facility Type | |
|---|---|
| Residential Group Homes | |

**ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Group homes with greater than three beds allow participants to live in residential neighborhoods in the community. Meals are served family style and residents access community activities, employment, schools or day programs. Per NDAC 75-04-01 it is the policy of the state to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Group Homes

**Waiver Service(s) Provided in Facility:**

| Waiver Service | Provided in Facility |
|---|---|
| Parenting Support | ☐ |
| Adult Day Health | ☐ |
| Adult Family Foster Care | ☐ |
| Extended Home Health Care | ☐ |
| Environmental Supports/Modifications | ☐ |
| Infant Development | ☐ |
| Family Care Option | ☐ |

| Waiver Service | Provided in Facility |
|---|---|
| **Homemaker** | ☐ |
| **Equipment and Supplies** | ☐ |
| **In-Home Supports** | ☐ |
| **Extended Services** | ☐ |
| **Behavioral Consultation** | ☐ |
| **Day Habilitation** | ☐ |
| **Transportation Costs for Financially Responsible Caregiver** | ☐ |
| **Residential Habilitation** | ☑ |

**Facility Capacity Limit:**

N/A

**Scope of Facility Sandards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

| Standard | Topic Addressed |
|---|---|
| Admission policies | ☑ |
| Physical environment | ☑ |
| Sanitation | ☑ |
| Safety | ☑ |
| Staff : resident ratios | ☑ |
| Staff training and qualifications | ☑ |
| Staff supervision | ☑ |
| Resident rights | ☑ |
| Medication administration | ☑ |
| Use of restrictive interventions | ☑ |
| Incident reporting | ☑ |
| Provision of or arrangement for necessary health services | ☑ |

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

N/A

# Appendix C: Participant Services

## C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C -2-d. *Select one*:

**The State does not make payment to relatives/legal guardians for furnishing waiver services.**

**The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives who are not legal guardians and not living in the same home as the eligible consumer may be paid for providing waiver services if they meet all other requirements.

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Enrollment is open to all entities that meet the licensure requirements. NDAC 75-04-01 details the requirements, application process and appeal rights. Application materials are available on request or on-line.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Qualified Providers**

**i. Sub-Assurances:**

**a.** ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(C-1) Annually, 100% of providers will be reviewed to assure compliance with licensing requirements.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Provider Licensed Database**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**b.** ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(C-2) 100% of Non-Licensed Providers will meet Qualified Service Provider (QSP) Standards, per NDAC 75-03-23.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Medical Services QSP enrollment**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(C-3) The Fiscal Agent will assure that 100% of Vendors receiving payment and individuals being reimbursed meet qualifications specified in this appendix.**

**Data Source** (Select one):
**Financial records (including expenditures)**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☑ **Stratified**<br>Describe Group:<br>Based on service |
| | ☐ **Continuously and Ongoing** | ☐ **Other** |

| | | |
|---|---|---|
| | | Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(C-4) Within 18 months of their date of hire, 100% of full time provider staff will successfully complete the fourteen required training modules as established by the DD Division.**

**Data Source** (Select one):
**Training verification records**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |

| | | |
|---|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Individual Provider issues will be dealt in accordance with NDAC 75-04-01 and training issues per DD Division Policy. When licensing deficiencies are discovered, specific plans of correction will be required in order to maintain licensure standards.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

To track the amount of services authorized for services that have a cap based on the duration of the waiver, by 7-01-09 the authorization database will be updated to track the amount authorized and utilized to prevent over-expenditure.

By 1-01-10, a new rate setting and reimbursement methodology will be developed and implemented for Infant Development Services. Time studies are currently being conducted as the first step towards identifying appropriate fees for specific activities. Six months after the initiation of the waiver will be required to design the new methodology, make needed system and administrative code changes and provide training to Infant Development agencies.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the

state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
*Furnish the information specified above.*

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
*Furnish the information specified above.*

☐ **Other Type of Limit.** The State employs another type of limit.
*Describe the limit and furnish the information specified above.*

# Appendix D: Participant-Centered Planning and Service Delivery

## D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**
Person Centered Service Plan/Individual Family Support Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

For individuals receiving waiver services other than Residential and Day Habilitation, their Person Centered Service Plan will be developed by the DD Program Manager. These Program Managers must be Qualified Mental Retardation Professionals (QMRP).

☐ **Social Worker.**

*Specify qualifications:*

☑ **Other**

*Specify the individuals and their qualifications:*

For Individuals receiving Residential Habilitation and Day Habilitation, the Person Centered Service Plan will be developed by staff employed by Licensed DD Service Providers and who are Qualified Mental Retardation Professionals (QMRP) or individuals who have a bachelor's degree, Developmental Disabilities module certified, and one year experience working with individuals with Developmental Disabilites.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

- **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

A checklist outlining the required components of the Person Centered Service Plan will be used by the DD Program Managers to assure that the service plan contains all required components. A plan developed by a service provider must be approved by the participant and the DD Program Manager.

Safeguards to ensure that service plan (PCSP) development is conducted in the best interest of the individual are evident when an individual or their legal decision maker chooses a service provider from a list of all qualified providers. A list of qualified providers will be given to the waiver participant and/or their legal decision maker at the time of waiver enrollment and annually thereafter or whenever the recipient voices a complaint or concern. The list will be contained in a packet which also includes additional rights of the recipient including a rights and responsibilities brochure, contact information for the DD program manager, the appeals supervisor (to request a Fair Hearing).

Once an individual or their legal decision maker selects a provider they acknowledge that they made an independent choice when signing the Individual Service Plan. The right to a choice of service provider is printed at the top of the ISP document along with other recipient rights.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

All waiver recipients and legal decision makers are active participants in the service plan development. The DD Program Manager will provide written information to all waiver recipients and/or their legal decision maker that will describe their right to direct and be actively engaged in the service plan (PCSP) development process including their right to determine who is included in the process. This will be included in the rights packet of information that will also describe the services available, their rights and responsibilities including their right to choose between and among waiver services, service providers and the right to request a Fair Hearing. The DD Program Manager will provide this information to the individual/legal decision maker at the time of waiver enrollment and annually thereafter prior to the service plan. In addition, a self-assessment, or in the case of infants and toddlers, a routines-based interview will be conducted with the recipient and/or legal decision maker prior to each service plan that will identify personal goals, preferences, and outcomes that will be incorporated into the plan. The individual/legal decision maker will be given the opportunity to determine a convenient date, time and location for the development of the plan. Once the plan is developed, the recipient/legal decision maker signs that they are in agreement with the plan.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and

policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The individual service plan for the waiver application is referred to as the Person Centered Service Plan (PCSP). Within the State of North Dakota, the service plan may be referred to under a variety of titles including Individual Support Plan, Life Plan, etc. and the Individual Family Support Plan (IFSP) for infants and toddlers receiving early intervention services.

The PCSP is developed through a person-centered planning process led by the individual and/or legal decision maker to the extent they desire. Person-centered planning is about supporting individuals to realize their own vision for their lives. It is the process of building effective and collaborative partnerships with individuals and working in partnership with them so that the plan helps them to reach their outcomes and goals. The plan identifies strengths and capabilities, desired training goals identified by the individual, and support needs. The start of the PCSP begins at the time of enrollment. At the time the individual is entering the waiver, the DD Program Manager (DDPM) will complete an evaluation instrument to help identify the individual's specific areas of strengths and needs. A Risk Assessment checklist will also be completed with the individual/decision maker to identify potential risks to the individual and how the risks are currently being addressed. The DDPM will also begin the discussion of what is important to the individual, and why e.g., outcomes and goals.

A copy of the waiver packet information will be provided to the individual/legal decision maker and the DDPM is available to answer any questions regarding available services. The packet contains eligibility requirements, service definitions, individual budgeting information and information about the planning process as well as information regarding their right to choose: between institutional and waiver services; right to choose among and between waiver services; right to select qualified provider(s) and the rights to appeal. The DDPM will document the individual's identified outcomes and requested services in the Case Plan in ASSIST. The Case Plan will also list other services, including the amount and frequency, the individual is currently receiving, regardless of funding source.

The DDPM will assist the individual and/or legal decision maker in referral to the waiver provider(s) of services they choose. The DDPM will coordinate the scheduling and location of the initial plan with the individual/legal decision maker and service provider(s). The individual/legal decision maker will be given the opportunity to suggest a date, time and location that are convenient for them and to identify who they wish to participate in the development of the plan. If there are sensitive topics that the individual does not want discussed in an open setting, agreement will be made on how these will be handled and with whom they will be discussed.

In addition to the individual, legal decision maker, DDPM and service provider, additional planning team members may include family, friends, advocates and other community supports. Staff members who work most closely with the individual providing direct support and care, and know the individual best are encouraged to participate and will be invited to participate if the individual/legal decision maker agrees. The PCSP will be submitted to the DD Program Administrator within 2 weeks of the meeting for review and final approval by the Medicaid agency.

Assessments:

A variety of assessments are completed to support the planning process including:
Person-Centered Information: Often referred to as a "self-assessment" or for infants and toddlers a "routines based interview" this involves what is most important to the individual from their perspective and the perspective of others that care about the individual. It involves identifying the individual's strengths, preferences, and needs through both informal and formal assessment process.
Risk Assessment: This assessment assists the individual and the team in identifying significant risks to the participant's health and safety.

Information about Support Needs:

This information assists in assuring that the participant receives needed services, and at the same time individuals do not receive services that are unnecessary, ineffective and/or do not address the participant's identified needs. This can include information from the evaluation instrument completed by the DD Program Manager, medical and health service information, adaptive skills assessment, and/or other formal assessment of the participant's support needs.
Additional Formal Evaluation: These may include evaluations by professionals and can include physician recommendations, nursing assessments, OT, PT, speech therapy, vocational, social work, psychology/behavior analysis, adaptive behavior scales, vocational leisure, recreation, or other evaluations as needed.

Prior to the Person Centered Support Planning Meeting:

The DD Program Manager will contact the individual/legal decision maker to review the services selected. If the individual/legal decision maker is interested in participating in receiving a self-directed service, the DD Program Manager will provide information and orientation to self-directed supports and will work with them to develop an individual budget amount and answer any questions regarding the Budget. If the individual is receiving an individually authorized service such as Family Support Services or Individualized Supported Living Arrangement, the DD Program Manager will review the authorization with the individual/legal decision maker. In addition, the DDPM will review the freedom of choice as it relates to institutional vs. home and community- based waiver services; choice between and

among waiver services; free choice of qualified provider(s); and right to appeal.

The individual/legal decision maker will be assisted to schedule the meeting and invite team members to the meeting at a time and location that is desirable for the participant.

The Individual Support Plan Meeting:

The individual/decision maker and team members including the DD Program Manager and service provider will review all issues that were identified during the assessment processes. Information is organized in a way that allows the individual and decision maker to work with the team and have open discussion regarding issues to begin action planning.
The planning meeting will include the agreed upon outcomes, any identified training goals, service objectives, activities and preferred methods used to meet the individual's needs, and mitigation strategies for identified risks. The goals and objectives should be measurable with criteria assigned to measure progress.

Discussion will also address monitoring the participant's services and supports (including any self directed services or individually authorized services) and decisions are made regarding team members responsibilities for service implementation and monitoring. While the DD Program Manager is responsible for in–depth monitoring of the PCSP and the individual's situation, in the case of "24/7" services, the service provider(s) will be responsible for program implementation, staff training, monthly data collection and summary of individual status, coordination of supports and activities including scheduling health care appointments, arranging for leisure, volunteer, church or religious activities, shopping or other day to day activities. For individuals residing in the home of a primary caregiver and receiving intermittent services, some of the coordination for the day to day activities and monitoring may be provided by the family.

Plan Approval:

The DD Program Manager will provide final approval of the PCSP by the Medicaid agency. Once the PCSP is approved, the DD Program Manager will preauthorize the home and community based services (by activating the Case Plan) that verify that there is a proper match between the participant's needs and the service(s) provided. The preauthorization will then be entered into MMIS for billing purposes. The Case Manager will print a copy of the Case Plan which lists the services, amount and frequency of services, and start and end date for each service. A copy of the Person Centered Service Plan, Case Plan and ISP will be sent to the individual/legal decision maker and the service provider of each waiver service. If the individual receives any individually authorized services such as Family Support Services or ISLA, a copy of that authorization will also be printed and sent to those named above.

The individual and/or legal decision maker and a delegated representative from each HCBS service provider must sign the ISP and return it to the DDPM for their final signature. The following rights are printed on the ISP and the signature of the individual/legal decision maker on the ISP indicates that they have: a) Received a copy of their rights and understand them; b) Been informed of their right to request a change of Case Manager; c) Been informed of Protection and Advocacy Services; d) Been informed of their right to select institutional services or waiver services (if the ICF/MR level of care is met); e) Been informed of their right to a choice of service provider(s); f) Received information regarding their right to appeal; g) are in agreement with the services listed on the ISP; h) understand that for services requiring Title XIX funding they must maintain Medicaid eligibility or private pay for those services.
Updates/Changes to the plan

The plan is updated at least annually (one year minus one day). In addition, the plan will be revised or updated when there is a significant change in the individual's needs due to change in the health or mental status of the individual; as goals and objectives are, or are not realized, when an individual is moved from one setting to another or to another service, etc. If there is a change that involves a change in the budget or individual authorization the individual budget or authorization is also updated. The individual/legal decision maker and any team member can request a team meeting for plan revisions.

Interim service plans may be developed for consumers who require services immediately once Medicaid waiver eligibility has been determined, and the program management entity is not able to make a face to face visit on the day the service is requested. Interim service plans may also be developed for consumers who are affected by natural disaster or other emergencies who require services immediately once Medicaid waiver eligibility has been determined, or to ensure continuity of waiver services if the disaster occurs at the time the annual service plan needs to be reviewed and updated and the program management entity is not able to make a face to face visit as required. Interim service plans can begin the day that the consumer is found to be eligible for waiver services and cannot extend beyond the first 60 days of initial waiver eligibility, or the first 60 days of the annual service plan year, at which time the full comprehensive service plan must be implemented in order to continue the delivery and reimbursement of waiver services.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The DD Program Manager will complete the Risk Assessment Checklist with the individual and/or legal decision maker at the time of intake and initial waiver enrollment. This information will be reviewed by the team at the admission/interim meeting held when the individual begins waiver services. Mitigation strategies will be incorporated for each identified risk into the plan. The Risk Assessment checklist will be updated at least annually or whenever the status of the individual warrants a change in the plan to assure that all risks are identified and mitigation strategies are developed, documented, and implemented. The individual and/or the legal decision maker will be involved in the completion of the checklist and development of mitigation strategies during the plan development process and will have the opportunity to approve the plan prior to implementation of the plan.

For individuals who are supported in their own private residence or other settings where staff might not be continuously available, an effective, individualized back up plan must be incorporated into the Person Centered Service Plan (PCSP). Such back up arrangements may include: programmed contact number for designated provider agency to furnish staff support on an on-call basis; notification of family member or neighbors, routine or periodic check by provider agency to assure direct support staff arrive on shift as assigned (preventative).

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Individuals and their legal decision makers will be given a list of qualified providers of waiver services upon waiver enrollment and prior to their Person Centered Service Plan or Individual Family Support Plan, as well as on an annual or as needed basis. The DD Program Manager will assist the individual to tour facilities or meet with providers selected by the individual. A list of services and providers is also available on the web. If an individual does not indicate a preference of qualified provider, the DD Program Manager, upon request, will submit referral information to the Regional Referral Committee or Committees, which is comprised of qualified HCBS Waiver Providers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

DD Program Managers will attend the Person Centered Planning Meeting. Within two weeks of the meeting, the Provider will send the final draft of the plan to the DD Program Manager. If there are individually authorized services, the authorizations will be reviewed and approved by the Regional DD Program Administrator and DD Division. Once the authorizations are approved, the DD Program Manager will complete the case plan in ASSIST which lists all waiver and other services regardless of funding source, amount, scope, and frequency. A copy of all will be provided to the individual, and/or legal decision maker and service provider(s). Approval of the plan will be indicated by the signature of the individual and/or decision maker, Provider Representatives, and DD Program Manager.

If the waiver recipient is receiving Infant Development services, the Infant Development Provider will enter present level of performance, outcomes/criteria/methods, and other client-specific information in ASSIST. The DD Program Manager will assure that other generic and formal support information is also entered before reviewing the plan for compliance and accepting the plan on behalf of the Medicaid Agency.

When waiver consumers receive In-Home Supports, the DD Program Manager will incorporate the assessment and outcome information provided by Family Support Service providers into a Person Centered Plan within ASSIST.

The Program Manager will develop Person Centered Outcomes within ASSIST for waiver recipients receiving any self-directed supports within this waiver.

To ensure portability of funding and initial access to individually authorized services (Individualized Supported Living Arrangement - ISLA and Family Support Services - IHS, FCO and FCO III) regional allocations will not be used to manage access to those services. DDD -PI-096(December 15, 2008) applies to access and portability of service funding for available waiver slots.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The DD Program Manager is responsible to monitor the overall service plan and the health and welfare of the participant. If their health and welfare requirements cannot be met by the plan; the program manager must initiate applicable changes or terminate waiver services. The recipient will be made aware of the right to a Fair Hearing if services are denied, reduced or terminated. The Provider Agency is responsible to oversee the day to day implementation of activities to reach individual training goals and outcomes for which they are responsible.

The individual and/or their legal representative, DD Program Manager, and Provider Agency will prepare a specific plan describing the way in which services will be carried out.

If there are serious incidents or abuse, neglect and/or exploitation, the provider will immediately address any risk management relative to health and welfare. All serious events and reports of suspected abuse, neglect, and exploitation are reported to the DD Program Administrator, Protection and Advocacy Project and/or Child Protective Services, and the State DD Division. The DD Program Manager conducts in-depth monitoring on a quarterly basis and will address follow-up relative to serious events, verification that any recommendations relative to abuse, neglect, and exploitation have been implemented to prevent reoccurrence, face to face visits with the individual, contact with the legal decision maker to discuss satisfaction with services, to determine that services are delivered as planned, and the effectiveness of services, including progress made toward identified outcomes, and the effectiveness of the backup or emergency plans. The results of each quarterly review and recommendations will be provided to the direct service Provider Agency, and the individual and/or legal decision maker, and documented within the Quality Enhancement Review. In the event there are concerns that cannot be addressed at the local level, the State DD Division will be notified and intervene when necessary. Other avenues to initiate followup and remediation are review of data by the DD Division, informal complaints, information from CQL, or trends identified by Quality Improvement Specialists.

For the first two years, the DD Division and DD Regional Program Administrators will review a sample yielding a 90% confidence

interval of QERs for compliance with policy and protocols. By year three of the waiver, fields will be added to the QER to facilitate electronic monitoring of 100% of the cases to determine the sample size of cases not meeting all monitoring criteria. A sample yielding 95% confidence interval will receive targeted monitoring to further identify trends.

Providers of direct service are responsible to monitor the day to day implementation of activities to reach individual training goals and outcomes for which they are responsible.

**b. Monitoring Safeguards.** *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

**i. Sub-Assurances:**

**a.** ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(D-1) 95% percent of individual evaluations in ASSIST will meet standards.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |

| | | |
|---|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>By age, service and DD Program Administrator |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☑ **Other**<br>Specify:<br>Biennially | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Biennially |

**b.** ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(D-2) 100% of Person Centered Service Plans will meet State requirements identified in the Person Centered Planning Requirements Checklist.**

**Data Source** (Select one):
**Record reviews, on-site**

If 'Other' is selected, specify:

| **Responsible Party for data collection/generation** *(check each that applies):* | **Frequency of data collection/generation** *(check each that applies):* | **Sampling Approach** *(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group: By age, service, Program Manager, and Region. |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Biennially |

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(D-3) 95% of Person Centered Service Plans will be completed/updated annually (one year minus one day).**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**ASSIST queries**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Every two years in conjunction with Human Service Center Licensing Review. |

**d.** ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(D-4) 95% of Quality Enhancement Reviews (QERs)that have been completed in accordance with policy requirements.**

**Data Source** (Select one):
**Record reviews, off-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>By service and DD Program Manager |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Every two years in conjunction with Human Service Center Licensing Reviews. |

**e.** ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(D-5) 95% of participants will have a signed statement ,per ISP, in case files stating that their rights have been explained to them.**

**Data Source** (Select one):
**Record reviews, on-site**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |

| | | |
|---|---|---|
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>By age, service, and Program Manager |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Biennially |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The DD Program Manager is responsible to assure that the Person Centered Service Plan (PCSP) contains the requirements set forth by the State. The approval allows payment to occur for authorized waiver services. Providers will not be able to bill until approval

is completed.

The Quality Enhancement Review includes a 90 day face-to-face visit with the participant, record review of program implementation, verification of incident remediation and consumer satisfaction. Contact will also be made with the legal decision maker if applicable. PCSPs will be revised or modified as needed based on review.

The DD Division reviews DD Program Management at each Regional Human Service Center every two years. Case reviews are completed to assure compliance with all requirements for the PCSP. Failure to meet policy requirements will result in Human Service Center licensure corrective action.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☑ **Other**<br>Specify:<br>Biennially |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The QER will be modified to facilitate aggregation of quantitative data and implemented by 10-31-09. The DD Division will be responsible for monitoring QER Data every six months.

The DD Division will implement a Person Centered Service Plan (PCSP) checklist that will identify the specific areas/components that must be addressed in every PCSP by 10-1-09.

The DD Division will implement a Uniform Risk Assessment checklist by 10-1-09. This checklist will be used to assess risk in order to plan for referral to services and to assure risks can be addressed by the initial PCSP at the time of admission to waiver services. It will also be completed at least annually and reviewed during development of the PCSP so mitigation strategies for each identified risk can be addressed in the plan.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- ○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

### E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants determine the vendors/providers from whom they will purchase services and supports. They will also negotiate the cost. Participants will have the opportunity to determine their priorities within the waiver budget limitations. DD Program Managers and Fiscal Agent staff will support participants as they self direct. Information regarding risk and responsibility involved in self direction, recommendations and considerations when selecting a vendor is provided in writing for participants and the material is reviewed with them. Guidance regarding key decisions and assistance in prioritizing needs will also be offered.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ◉ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

Self Directed Services consist of Behavior Consultation, Environmental Supports/Modifications, Materials and Supplies, and Excess Transportation Costs for Parents of Minor Children. These services are, solely, participant-directed. In-Home Supports and Extended Services can be either participant-directed or provider managed.

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Participants considering Participant Directed Supports, upon enrollment and annually, DD Program Managers review written information with consumers and/or their legal decision makers regarding:
a. describes benefits and potential liabilities associated with participant direction of services;
b. responsibilities of participants;
c. support available through DD Program Managers and the Fiscal Agent;
d. component of a Person Centered Plan and their responsibility in its development;
e. information available on the fiscal agent's website

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- **The State does not provide for the direction of waiver services by a representative.**
- **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- [x] **Waiver services may be directed by a legal representative of the participant.**
- [ ] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

| Participant-Directed Waiver Service | Employer Authority | Budget Authority |
|---|---|---|
| Environmental Supports/Modifications | ☐ | ☑ |
| Family Care Option | ☐ | ☑ |
| Equipment and Supplies | ☐ | ☑ |
| In-Home Supports | ☐ | ☑ |
| Extended Services | ☐ | ☑ |
| Behavioral Consultation | ☐ | ☑ |
| Transportation Costs for Financially Responsible Caregiver | ☐ | ☑ |

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C1/C3**

**The waiver service entitled:**

◉ **FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Contract Entity

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Monthly fee for service

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☐ **Assists participant in verifying support worker citizenship status**
- ☐ **Collects and processes timesheets of support workers**
- ☐ **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

*Specify:*

Supports furnished when the participant exercises budget authority:

- ☑ **Maintains a separate account for each participant's participant-directed budget**
- ☑ **Tracks and reports participant funds, disbursements and the balance of participant funds**
- ☑ **Processes and pays invoices for goods and services approved in the service plan**
- ☑ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☑ **Other services and supports**

*Specify:*

Maintain a secure FTP website that allows DD Program Managers to track participant's budget and expenditures.

Additional functions/activities:

- ☑ **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☑ **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☑ **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The performance of the Fiscal Agent is reviewed by the DD Program Manager with the participant and/or legal representative during a quarterly meeting, any concerns are documented in the Quality Enhancement Review document that is forwarded to the Regional DD Program Administrator and DD Division, if the issue cannot be resolved by the DD Program Administrator and participant and/or legal representative. DD Division has frequent (at least every quarter) conference calls with the contracted Fiscal Agent to review issues identified through data analysis of Quality Enhancement Reviews. The authorization process prevents over billing by the Fiscal Agent as the MMIS has edits that prohibit payments in excess of authorized budget limits. DD Division Staff monitor monthly budget program spenddown reports generated through MMIS and monthly contract billings for Fiscal Agent services. As outlined in the contract with the North Dakota Department of Human Services, the Fiscal Agent also has agreed to have an independent audit conducted and will share the results.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished

by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

☐ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

| Participant-Directed Waiver Service | Information and Assistance Provided through this Waiver Service Coverage |
|---|---|
| **Parenting Support** | ☐ |
| **Adult Day Health** | ☐ |
| **Adult Family Foster Care** | ☐ |
| **Extended Home Health Care** | ☐ |
| **Environmental Supports/Modifications** | ☐ |
| **Infant Development** | ☐ |
| **Family Care Option** | ☐ |
| **Homemaker** | ☐ |
| **Equipment and Supplies** | ☐ |
| **In-Home Supports** | ☐ |
| **Extended Services** | ☐ |
| **Behavioral Consultation** | ☐ |
| **Day Habilitation** | ☐ |
| **Transportation Costs for Financially Responsible Caregiver** | ☐ |
| **Residential Habilitation** | ☐ |

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

Qualified Mental Retardation Professionals, employed by the Department of Human Services, Regional Human Service Centers, provide support brokerage. This is claimed as an Administrative Activity.

DD Program Managers meet with the consumers and/or their legal representatives to review information regarding the roles, risks, and responsibilities involved with Self Directing Supports. They connect them to the Fiscal Agent, provide practical skills training to assist them with directing services, assist them with locating sources of waiver goods and services and developing budget management skills.

The DD Division conducts biennial licensing reviews of the activities of the Regional Program Managers function. The review includes compliance with established protocols and policies regarding Support Brokerage activities.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

Participants will be informed of availability of representation from the ND Protection and Advocacy Project. If requested, DD Program Managers will assist participants in accessing services with the ND Protection and Advocacy Project. The Protection and Advocacy Project does not furnish other direct services or perform waiver functions.

## Appendix E: Participant Direction of Services

### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The DD Program Manager will review the ramifications of voluntary termination, including possible impact on Medicaid and health and safety issues for the eligible consumer. Other support options including Medicaid State Plan services, other waivers will be explored. The DD Program Manager will assist the participant and/or legal representative in transition activities. Waiver services will continue during the transition period.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the roles and responsibilities identified in the Person Centered Plan are not carried out and it is directly impacting the health and safety of the eligible consumer, the DD Program Manager will notify the participant that services are being terminated and review their right to appeal the termination of services offered through this waiver. Other support options including Medicaid State Plan services and other waivers will be explored. The DD Program Manager will assist the participant in transition activities.

The Participant Agreement and the Budget Authorization for self directed services describes circumstances under which the service will be terminated. Services will continue during the transition unless there are situations that immediately impact the health and safety of the individual.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

**Table E-1-n**

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| **Waiver Year** | **Number of Participants** | **Number of Participants** |
| **Year 1** | | 400 |
| **Year 2** | | 420 |
| **Year 3** | | 441 |
| **Year 4** | | 463 |

| | Employer Authority Only | Budget Authority Only or Budget Authority in Combination with Employer Authority |
|---|---|---|
| Waiver Year | Number of Participants | Number of Participants |
| Year 5 | | 486 |

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☐ **Hire staff common law employer**
☐ **Verify staff qualifications**
☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☐ **Schedule staff**
☐ **Orient and instruct staff in duties**
☐ **Supervise staff**
☐ **Evaluate staff performance**
☐ **Verify time worked by staff and approve time sheets**
☐ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

After the consumer and/or their legal representative has completed the Family Support Program Application, the DD Program Manager will develop the individualized budget. The budget will be based on the specific support needs of the eligible participant, generic and informal resources available, and risk of unwanted out-of-home placement. Individualized budgets identify the funds that will be available for each budget line item. Transportation reimbursement will be projected based on state guidelines. The amount authorized for other self-directed supports will be negotiated based on anticipated costs. Consumers and/or their legal representatives will sign all individualized authorizations to indicate their approval and acknowledge their right to appeal. All individualized authorizations are also reviewed by the Regional DD Program Administrator and must be approved through the DD Division before services can begin. All authorizations are reviewed after the quarter to audit the authorization back to the actual amount of funds utilized. This information is then considered as the next authorization is developed.

All Developmental Disability Policies reflecting Budget Authority will be available via the Department's website and all Division Policies are distributed according to a mailing list of stakeholders and interested parties.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

**b. Participant - Budget Authority**

**iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Consumers and/or their legal representative will sign all individualized authorizations to indicate their approval of the projected budget and acknowledge their right to appeal. If during the authorization period it becomes necessary to transfer funds from one budget line item to another or if additional funds are needed, the consumer and/or their legal representative will request a meeting with their Regional DD Program Manager to re-negotiate their budget.

The consumer is informed of the opportunity to request a Fair Hearing when a request for a budget adjustment is denied or the amount of the budget is reduced through the Budget Authorization form. The consumer signs this form before services can begin.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

**b. Participant - Budget Authority**

**iv. Participant Exercise of Budget Flexibility.** *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

**b. Participant - Budget Authority**

**v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Fiscal Agent has developed an on-line budget balance sheet that indicates total budget, percentage of expenditures and remaining funds. This information is available to the DD Program Managers. The participants and/or their legal representatives receive the same information as payments are made or on a monthly basis if requested. Participants and/or their legal representatives may also call the Fiscal Agent for updated information.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of

their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The individual and/or legal decision maker will be given notice of their right to a Fair Hearing if they are not given the choice of Home and Community Based Services as an alternative to institutional care, are denied the service(s) of their choice, or the providers(s) of their choice; or whose services are denied, suspended, reduced or terminated. Notification of Rights at a minimum are provided to each waiver recipient by the Program Manager at enrollment, prior to annual Person Centered Service Plan Review, and whenever a recipient registers a concern regarding services.

In addition to the above procedures, parents of infants and toddlers, birth to three, receive a brochure describing their rights to request mediation, file a complaint, or request an appeal.

The authorizations for all Family Support Services and Self Directed Services provide quarterly notice of rights to appeal adverse actions regarding reduction, denial, or termination of services. Families must sign and return the authorization on a quarterly basis prior to services being initiated for that quarter. DD Program Managers mail the authorization to families and are available to assist the family with questions concerning exercising their rights.

DD Program Managers keep copies of written correspondence regarding Notice of Adverse Actions, signed ISPs and Authorizations at the Regional Human Service Centers.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The ND Department of Human Services assures an individual who is dissatisfied with any decision or action, may request an informal conference in an attempt to resolve the issue. The request for formal conference must be submitted to the Regional Human Service Center Director per DDD-PI-094. The use of informal conference will not preclude or delay the individual's right to a fair hearing. Regional DD Program Manager will provide assistance to the grieved individual with submitting an informal appeal and to describe the process of appeal.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

# Appendix G: Participant Safeguards

## Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The definitions for Abuse, Neglect and Exploitation and the role of the Protection and Advocacy Project are defined in North Dakota Century Code 25-01.3. Definitions for child abuse and neglect for individuals under the age of 18 and the role of Child Protective Services are contained in NDDC Chapter 50-25.1 Child Abuse and Neglect. In addition, the Developmental Disabilities Division has developed policies and procedures for entities that provide services to waiver recipients regarding the reporting and follow up of Serious Events including abuse, neglect and exploitation. (DDD-PI-006). Providers of home and community- based waiver services are required to report serious events and alleged abuse, neglect and exploitation. DD Program Managers are also mandatory reporters.

All Serious Events (formerly referred to as Class 1 incidents in policy) shall be reported to, and assessed by an independent third party. For participants age 18 and older, the Protection and Advocacy Project will be responsible to receive the reports, assess the need for further follow up and conduct the investigation if indicated. If the participant is under the age of 18 years, Child Protective Services will receive the report and take the lead in assessing the need for follow up and investigation.
Serious Events must be verbally reported to P&A or Child Protective Services within 8 hours of the event. DD service providers should not initiate an internal investigation when a serious event occurs. Service provider action shall consist of: immediately implement appropriate risk management; reporting to P&A/Child Protective Services within 8 hours and completing a written report to P&A, Child Protective Services, the Regional DD Program Administrator and the State DD Division within one working day. When the event is a participant death, the service provider will also provide verbal notification to the regional DD Program Administrator and State DD Division within one working day. A written report must be submitted within 7 days to P&A, Child Protective Services if appropriate, Regional DD Program Administrator and State DD office. If the individual has a legal decision maker, they will be notified of the serious event. The Service Provider will notify the guardian/parents of a serious event.

All incidents that do not meet the criteria for a Serious Event are reviewed by the service provider utilizing the “Reporting Determination Guidelines” that are contained in DDD-PI-006. If the incident meets any of the guidelines, the service provider is required to implement appropriate risk management and report the incident to P&A, the Regional DD Program Administrator and the State DD Division within one working day with a written incident report within 3 days. If the individual is under the age of 18, the service provider will notify Child Protective Services (CPS). The service provider is also required to notify the legal decision maker of the incident.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or

legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DD Program Managers provide participants and their legal decision makers with written information regarding the "DD Bill of Rights", Century Code 25-01.2 and definitions of abuse, neglect and exploitation. The information will be presented at a level consistent with the individual's level of understanding and will include contact information to make a report. This information will be provided at the time of waiver enrollment and annually thereafter. Individuals who are in need of self advocacy training per risk assessment receive self-advocacy training as part of their Person Centered Plan. The Person Centered Plan will identify the entities responsible for providing the training and the frequency of that training.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receipt of the report, P&A or CPS will determine if the incident requires follow up by an independent third party. If it is determined that the incident does not meet the criteria for serious event and/or does not require investigation by an independent third party, the service provider will conduct an investigation within 5 working days of being informed that it doesn't require an independent investigation and submit their findings to P&A, the regional DD Program Administrator and the State DD Division. The specific requirements for the investigation are described in DDD-PI-006.

Upon receipt of the service provider's investigation report, P&A will submit a Letter of Findings indicating whether or not the incident is substantiated as abuse, neglect or exploitation and any recommendations for follow up. All investigations and findings from P&A will be reviewed by DD Division staff within three days of receipt.

The Regional DD Program administrator, individual's DD Program Manager and State DD Division review all reports and assessments completed by the service provider. The DD Division shall determine if additional information or reporting is required and may impose corrective measures upon the service provider. There may be situations when regional DD case management staff, State DD Division and P&A will conduct a joint review.

In all cases, the DD Program Manager will follow up on any reports during their quarterly in-depth monitoring to verify that the recommendations and plan to prevent reoccurrence was implemented. The DD Program Manager will also discuss the incident and findings with the consumer and/or legal decision maker to address any additional areas of concern during the Quality Enhancement Review process/ in-depth monitoring. Follow up related to the incident will be documented in the QER progress notes. The DD Program Manager will assist the individual or decision maker to address unresolved concerns with the service provider, and if necessary the State DD Division and P&A.

The level of DD Division involvement, coordination and monitoring regarding the reports and findings from Child Protection Services will be one of the components addressed within the Memorandum of Understanding between Child Protective Services and the Developmental Disabilities Division. This Memorandum of Understanding will be effective 4-01-09, and will remain in effect through the life of the waiver.

In order to identify children who are abused and neglected, to provide child protective services to children and their families, to facilitate the provision of Developmental Disability services to those children and their families, and to deliver services with effficiency and comprehensiveness, the ND Department of Human Services agrees to share information between two divisions, Children and Family Services and Develomental Disabilities as authorized by North Dakota Century Code 50-25.1-11(3).

Note: Child Protection Services is the state agency required by state law to enforce child abuse and neglect statutes for individuals under the age of 18. Child Protection Services is a division under the umbrella of the Department of Human Services.

**e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

All reports and findings for serious events and all other incidents reported as abuse, neglect and exploitation are entered into an Incident Management data base maintained by the State DD Division. The data is reviewed at least quarterly by the State DD Division and State Protection and Advocacy staff at their quarterly meeting.

In addition, monitoring of all service providers is conducted biennually by State DD Division and P&A staff. The monitoring includes a sample review of incident reports to determine if the service provider is reporting as required, utilizing the Reporting Determination Guidelines and conducting investigations as indicated in DDD-PI-006.

Based on requirements identified in the licensure code, providers will be required to be accredited by Quality and Leadership (CQL), meet case review standards, or other accountability and assurances required in code.

The level of DD Division involvement, coordination and monitoring regarding the reports and findings from Child Protection Services will be one of the components addressed within the Memorandum of Understanding between Child Protective Services and the Developmental Disabilities Division. This Memorandum of Understanding will be effective 4-01-09, and will remain in effect through the life of the waiver.

In order to identify children who are abused and neglected, to provide child protective services to children and their families, to facilitate the provision of Developmental Disability services to those children and their families, and to deliver services with effficiency and comprehensiveness, the ND Department of Human Services agrees to share information between two divisions, Children and Family Services and Develomental Disabilities as authorized by North Dakota Century Code 50-25.1-11(3).

When it is discovered that a child is receiving DD services, and is the subject of a Suspected Child Abuse and Neglect allegation, the Child Protective Service supervisor and Regional DD Program Administrator at the Regional Human Service Center will be notified. Child Protection Services will assess and investigate according to NDCC Chapter 50-25.1 (Child Abuse and Neglect). Regional Human Service Center DD Unit will provide assistance with such issues as whether or not the child's condition may be a contributing factor to the report, what services may be available to assist the child and family, or what services may be available to the child if out of home placement is required.

Note: Child Protection Services is the state agency required by state law to enforce child abuse and neglect statutes for individuals under the age of 18. Child Protection Services is a division under the umbrella of the Department of Human Services.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion.** *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All service providers must have written policy and procedures concerning behavior intervention and emergency procedures for controlling maladaptive behavior and must provide for a Behavior Management Committee and Human Rights Committee. The policy and procedures must emphasize positive approaches and define and list techniques that are used and available for use in their relative degree of restriction. Before highly restrictive emergency procedures can be implemented it is the responsibility of the planning team to perform and document a functional and ecological analysis (analyze the maladaptive behavior to determine the intent of the behavior, the antecedents of the behavior and whether environmental alterations, would reduce or eliminate it, or there is a medical cause for the behavior). The maladaptive behaviors should be targeted for reduction and the plan should specify the adaptive behaviors to replace the maladaptive behaviors. Less restrictive methods must be included in the plan and attempted prior to the application of restraint. The procedures must be designed and used so as not to cause physical injury to an individual and to minimize physical and psychological discomfort. Only a minimum amount of restraint necessary to control the individual's behavior can be used during the implementation of a restraint and used only until the individual is calm. The authorization and justification for the procedure and the period of restraint must be recorded. The restraint must be implemented only by trained staff and all protocols implemented must be documented. The emergency use of restraints must be developed with the participation of the individual served and or their legal decision maker who must consent to the program. The program using restraint must be submitted to a behavior intervention management committee and a human rights committee for review and approval prior to implementation.

Seclusion is prohibited. Physical restraint will not be used as a habilitative treatment or behavioral support option but may be briefly employed as a last resort in crisis situations. Planned physical restraint (personal and mechanical) can only be used in

emergency situations when necessary for the control of violent and aggressive behavior which may immediately result, or has resulted in harm to that person or to other persons or the risk of significant property destruction exists.
Planned chemical restraint used to manage violent and aggressive behavior must be administered under the authorization of a licensed physician and the plan must justify the use of the drug, assure the drug is within therapeutic dosage range and will not adversely affect the therapeutic benefits of other medications. The team, including prescribing physician, must determine that the person has reached the lowest effective dosage of the medication based on data symptoms and behavior of the individual. This documentation must be in the individual's plan and reviewed by the team and physician for as long as the person receives the medication.

Restraint (chemical, physical, or mechanical) used during the conduct of a specific medical/dental or surgical procedure, may be used only if absolutely necessary for the person's protection during the time that a medical condition exists. The physician/dentist must specify the scheduled use of restraint and its monitoring and utilization methods documented in the individual's service plan. The use of devices such as splints or braces, bedrails to prevent injury, wheelchair harnesses and lap belts to support a person's proper body positioning must be included in the individual's person-centered service plan including medical necessity and procedures for their use.

Unauthorized restraints are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DDD-PI-006. During onsite monitoring, Program Managers will assure that Individual Behavior Support Plans are implemented as approved. Waiver recipients and legal decision makers must approve and agree to behavior support plans and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

In order to meet licensure requirements of NDAC 75-04-01-20, providers must adopt and submit policies regarding restraints and restrictive interventions to the Department for review and approval.

**ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The established safeguards and requirements will be reviewed by the team including the DD Program Manager during the development of the Person Centered Service Plan. Monthly reviews of data will be compiled and reviewed at least monthly by the service provider responsible for implementation of the plan. The DD Program Manager will review the use of individual restraints during the Quality Enhancement Review on a quarterly basis to assure the safeguards and requirements are met and to assure that the approval of the individual/legal decision maker, behavior management committee and the Human Rights Committee is documented. This information will be recorded in the QER and any noncompliance or needed follow up regarding the use of restraints will be initiated and documented. Psychotropic medications will be documented in the PAR completed by the DD Program Manager.

The use of all unauthorized restraints (those not written into the individual's plan and approved by the Human Rights Committee and Behavior Management Committee) and all prone restraints (physical holding or any restraint of an individual in a face down position) regardless of whether it is included in the individual behavior plan, meet the criteria for a Serious Event and must be verbally reported to the Protection and Advocacy Project within 8 hours and a written report submitted to the individual's legal decision maker, Protection and Advocacy Project, Regional DD Program Administrator and DD Division within one working day. The Protection and Advocacy Project will be responsible for independent review and follow up. The DD Division will periodically review a stratified sample of individual records and incident reports annually to assure compliance with requirements. The DD Division and Protection and Advocacy Project will review the data to identify trends and patterns to support improvement strategies.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions.** *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The use of aversive methods or conditioning such as application of startling, unpleasant or painful consequences is prohibited. Designated Time Out rooms are not utilized, although the use of a quiet area or an individual's private bedroom may be used for the purpose of providing the individual an opportunity to regain self-control.
The procedures for behavioral intervention should be an improvement in quality of life for the individual and should not substitute for procedures to provide positive behavioral supports. Behavior plan development includes a functional and ecological assessment, efforts to use least restrictive methods, identification of the specific problem/target behavior to be decreased and replacement behavior to be increased. Staff must be trained prior to implementation of the plan.
All methods or procedures that limit freedom of movement, access to other individuals, locations or activities or rights must be reviewed and addressed by the service plan team and must be reviewed and approved by the individual and/or legal decision maker, the Behavior Management Committee if a behavior plan is utilized, and the Human Rights Committee prior to implementation. The plan must include a review schedule (minimum of annually) by the planning team including the individual/legal decision maker, Behavior Management Committee if a behavior support plan is in place, and the Human Rights Committee.
Monthly reviews of data will be compiled by the service provider responsible for implementation of the behavior support plan. The DD Program Manager will review the plan and data relative to the health and safety of the individual and compliance with designated protocols during the QER in-depth review conducted on a quarterly basis. This information will be recorded in the QER and any noncompliance or needed follow up regarding the use of restraints will be initiated and documented.
The use of restrictive interventions (those not written into the individual's plan and approved by the Human Rights Committee and Behavior Management Committee) or failure to implement restrictions within the parameters identified in the individual's plan as written must be reported to the individual's legal decision maker, Protection and Advocacy Project, Regional DD Program Administrator, and DD Division, and the incident investigated within 5 working days by the service provider with copies of the report submitted to the P&A project, DD Program Administrator and DD Division and findings communicated to the legal decision maker.

Unauthorized use of restrictive interventions are required to be reported as suspected abuse, neglect, or exploitation per North Dakota Administrative Code 75-04-01-20.2.2, Century Code 25-01.2-09, 25-01.2-10, and DDD-PI-006. During onsite monitoring, Program Managers will assure that Individual Behavior Support Plans are implemented as approved. Waiver recipients and legal decision makers must approve and agree to behavior support plans and are made aware that unauthorized use of restraints or restrictive interventions are not allowed and are required by law to be reported.

In order to meet licensure requirements of NDAC 75-04-01-20, providers must adopt and submit policies regarding restraints and restrictive interventions to the Department for review and approval.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Quality Improvement Specialist (QIS) will review a stratified sample of individual records and incident reports annually to assure compliance with requirements. The DD Division and Protection and Advocacy Project will review the data from the QIS and incident management system to identify trends and patterns to support improvement strategies.

For the first two years, the DD Division will review a sample yielding a 90% confidence interval. The sample size will be determined based on the number of individuals receiving waiver services who have restrictive interventions or restraints. By year three of the waiver, fields will be added to the QER to identify individuals with behavior intervention plans that include restrictive interventions or restraints. In addition to those individuals, the sample size will also include individuals from the incident report tracking data base where emergency restrictive interventions or restraints were used. A sample yielding 95% confidence interval will receive targeted monitoring to further identify trends.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Individuals living in facilities or served by residential programs operated by a licensed provider:

The Developmental Disabilities Division (DD Division) through the licensing process, reviews provider policies and procedures for compliance with North Dakota Century Code (NDCC) 25-01.2-07 and North Dakota Administrative Code (NDAC) 75-04-01-20.1.h regarding access to medical services and medication administration. License renewal is conducted annually for each licensed provider. Per DDD-Policy Issuance-044 a licensed provider serving non-self medicating persons must develop written procedures approved by a licensed medical practitioner for maintaining, retrieving, and controlling access to medication.

DDD-Policy Issuance-044 requires that non-licensed personnel administering medications must have completed the medication administration module of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review for those personnel must be conducted for continued competency to participate in medication administration. Minot State University Center for Persons with Disabilities administers the medication training system with certification of the Board of Nursing according to rules at NDAC 54-07 for Medication Assistant training programs. MSU maintains a record of personnel and training which are provided to the DD Division.

Medication administration errors are subject to reporting as potential abuse, neglect or exploitation as detailed in section G-1 above. DD Division staff review all such reports and a database is maintained which can identify trends in medication administration error reports.

Licensed providers are required to be accredited by the Council on Quality and Leadership (CQL). The Basic Assurances assessed by CQL include provision of health care with policies and procedures for medication administration. CQL survey reports for each licensed provider are provided directly to the DD Division.

Individuals living in the home of a legal decision maker:

Medication administration is delegated by the legal decision maker according to competencies identified in the Person Centered Service Plan.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The ND Board of Nursing certifies the statewide medication administration training program and licenses nurses that directly provide the training and delegate medication administration tasks. The certification process is completed every 4 years. The Minot State University Center for Persons with Disabilities operates the training program. Licensed nurses train personnel utilizing the MSU curricula and practica and certify individuals who have successfully completed training. Minot State also conducts quarterly meetings with staff trainers and the DD Division to evaluate training curriculum and process.

Medication errors that meet reporting determination guidelines as noted in G-1 above must be investigated and reported to the DD Division and Protection and Advocacy. Practices or conditions that suggest systemic issues with a providers medication administration practices must be addressed with a plan of remediation approved by the Division and P&A. Reported medication errors are included in a statewide A,N,& E database to allow determination of trends.

In addition, monitoring of all service providers is conducted biennually by State DD Division and P&A staff. To assess the effectiveness of training regarding Reporting Determination Guidelines, staff from the DD Division and Protection and Advocacy will review a sample of incident reports for a period of at least six months to determine if targeted retraining is needed. Sample size will be determined by the number of incident reports that have been completed in at least a 6 month time period that will yield an

accuracy level of plus or minus 10 percent at the 95% confidence level. Additionally, in conjunction with annual provider licensure, the DD Division Review Protocol will include review by a licensed medical professional of medication administration error records and practices.

Licensed providers are required to be accredited by the Council on Quality and Leadership (CQL). The Basic Assurances assessed by CQL include provision of health care with policies and procedures for medication administration. CQL survey reports for each licensed provider are provided directly to the DD Division.

# Appendix G: Participant Safeguards

## Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**i. Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DD Division through the licensing process reviews provider policies and procedures for compliance with NDCC 25-01.2-07 and NDAC 75-04-01-20.1.h regarding access to medical services and medication administration. License renewal is conducted annually for each licensed provider.

DDD-Policy Issuance-044 requires that non-licensed personnel administering medications must have completed the medication administration module of the ND staff training system and that medication administration is delegated by a licensed medical professional. Periodic review for those personnel must be conducted for continued competency to participate in medication administration. Minot State University Center for Persons with Disabilities administers the medication training system with certification of the Board of Nursing according to rules at NDAC 54-07 for Medication Assistant training programs. MSU maintains a record of personnel and training which are provided to the DD Division.

Medication administration errors are subject to reporting as potential abuse, neglect or exploitation. DD Division staff review all such reports and a database is maintained which can identify trends in medication administration error reports.

Licensed providers are required to be accredited by the Council on Quality and Leadership. The Basic Assurances assessed by CQL include provision of health care with policies and procedures for medication administration. CQL survey reports for each licensed provider are provided directly to the DD Division.

For individuals living in the home of a legal decision maker, medication administration is delegated by the legal decision maker.

**iii. Medication Error Reporting.** *Select one of the following:*

- ◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  *Complete the following three items:*

  (a) Specify State agency (or agencies) to which errors are reported:

  Medication errors are recorded by DD Licensed Providers. Medication errors that meet the Reporting Determination Guidelines, are reported to Regional DD Administrators, Regional Protection and Advocacy Project, and the DD Division.

  (b) Specify the types of medication errors that providers are required to *record:*

  Licensed DD Providers are required to record all medication errors. The types of errors recorded are as follows: a) wrong person, b) medication, c) dose, d) time and e) route, missed medication, refusal, count discrepancy and dropped medication.

(c) Specify the types of medication errors that providers must *report* to the State:

Reporting Determination Guidelines: Medical/Medication Error Review

1. ___ A medication was not administered according to doctor's orders and the consumer was harmed or placed at risk of harm (including having to repeat medical treatment or medication).

2. ___ A medical procedure was not administered or completed according to doctor's orders and the consumer was harmed or placed at risk of harm.

3. ___ A controlled substance is missing.

4. ___ Medication documentation is falsified (i.e., - signing the MAR before giving the medication).

5. ___ Professional Judgement indicates a need for review (i.e., - pattern of errors in a setting and/or by a staff; repeated errors for a particular consumer; non-medication certified staff dispensing medications; error indicates possible systems issues, etc.)

NOTE – Risk of harm is assessed by the consumer's physician, nurse, and/or pharmacist (preferably a medical person with knowledge of the consumer).

If any one of the above apply, and

1. ___ The incident could have occurred as reported (must apply)
2. ___ The incident may fall within the parameters of one or more of the statutory definitions of Abuse, Neglect and Exploitation according to NDCC 25-01.3 (must apply if the consumer is over 18 years of age).

The error must be reported according to DDD-PI-006.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The ND Board of Nursing certifies the statewide medication administration training program and licenses nurses that directly provide the training and that delegate medication administration tasks. The certification process is completed every 4 years. The Minot State University Center for Persons with Disabilities operates the training program. Licensed nurses train personnel utilizing the MSU curricula and practica and certify individuals who have successfully completed training. Minot State also conducts quarterly meetings with staff trainers and the DD Division to evaluate training curriculum and process.

Medication errors that meet reporting determination guidelines as noted above must be investigated and reported to the DD Division and Protection and Advocacy. Practices or conditions that suggest systemic issues with a providers med administration practices must be addressed with a plan of remediation approved by the Division and P&A. Reported medication errors are included in a statewide A,N,& E database to allow determination of trends.

In addition, monitoring of all service providers is conducted once every two years by State DD Division and P&A staff. To assess the effectiveness of training regarding Reporting Determination Guidelines, staff from the DD Division and Protection and Advocacy will review a standardized sample of incident reports for a period of at least six months to determine if targeted retraining is needed. Sample size will be determined by the number of incident reports that have been completed in at least a 6 month time period that will yield an accuracy level of plus or minus 10 percent at the 95% confidence level. Additionally, in conjunction with annual provider licensure, the DD Division Review Protocol will include review by a licensed medical professional of medication administration error records and practices.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**
***The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(G-1) The number of reported incidents where remediation recommendations were implemented as described in the investigation and letter of findings.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Quality Enhancement Review (QER) Database within Lotus Notes**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-2) The mortality rate of the served MR/DD population compared to the general area population, by age, by cause of death will be comparable to national statistics.**

**Data Source** (Select one):
**Mortality reviews**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-3)The incident rate of Child Protective Service investigations involving the served MRDD population compared to the general population, by numbers substantiated, by age, by type of incident, living arrangement, and by MRDD Diagnosis will be comparable to national statistics.**

**Data Source** (Select one):
**Other**
If 'Other' is selected, specify:
**Child Protection Services Data from Children and Family Services Division and demographic information in ASSIST.**

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other** | |

| | | |
|---|---|---|
| | Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-4) At least 85% of participants will report they like where they live, they like their job/school/day program, or that people do not hurt or scare them.**

**Data Source** (Select one):
**Analyzed collected data (including surveys, focus group, interviews, etc)**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☑ **Stratified**<br>Describe Group: Age, Living Arrangement, Provider, and Region |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |

| | | |
|---|---|---|
| | | |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(G-5) 95% of Participants and/or legal decision makers will report that they have been informed of investigation results.**

**Data Source** (Select one):
**Analyzed collected data (including surveys, focus group, interviews, etc)**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☑ **Stratified**<br>Describe Group:<br>By Provider |
| | ☐ **Continuously and Ongoing** | ☐ **Other** |

| | | |
|---|---|---|
| | | Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
To verify the accuracy of data, the number and percent of incidents that are correctly identified as reportable by providers, will be reviewed during biennual abuse, neglect, and exploitation training and monitoring by DD Division and Protection and Advocacy Project staff. Stratified samples by service type will be reviewed.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DD Program Managers will review incident investigations and implementation of recommendations to prevent reoccurrence. Unresolved issues related to implementation will be reported to the Provider to develop a corrective action plan. If the issue can not be resolved at this level, the Program Manager will inform the DD Program Administrator and DD Division for impact on licensure.
Quarterly meetings with the Protection and Advocacy Project to address review of incident report trends, training activities, incident report system policies and procedures, and results of reviews of provider internal incident practices.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The DD Division is investigating options to utilize a web-based application to facilitate more timely reporting and accurate collection of data.

The method to share information between Children and Family Services and the DD Division will be developed by 1-01-10.

The DD Division will develop a protocol to implement periodic on-site visits (Quick Checks) to Residential and Day Services waiver facilities to assess general conditions of environment, peer to peer interaction, staff to peer interactions, and general appearance of individuals by 1-01-10.

By April 1, 2009 the DD Division will have updated Policies relative to Behavior Management and Human Rights Committees and Policy and Practice regarding Personal, Drugs, Mechanical Restraints and Seclusion.

The DD Division will enter into a memorandum of understanding with partners such as the Council for Quality and Leadership (CQL) regarding data collection and aggregation. The initial MOU will be developed by 1-01-10.

The DD Division will provide training to Human Rights Committees by April 1, 2010.

A protocol will be developed to identify the degree of accuracy of Provider review of incidents with the Reporting Determination Guidelines by 7-01-09.

The DD Division will develop a policy to require periodic participation of Regional DD Program Administrators or designee in Provider incident reviews to ensure compliance with reporting per DD-PI-006 by 1-01-10.

The State plans to implement the following by 10-1-09.

1. Uniform incident report form.
2. Reporting of all serious incidents to P&A or CPS for independent assessment or investigation regardless of whether the reporting guidelines are met.
3. Uniform client death notification form.

## Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

### H-1: Systems Improvement

**a. System Improvements**

**i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DD Division will aggregate data and analyze the data using charts and other visual depictions when they meet quarterly to review and analyze data for all performance measures. Trends will be identified and grouped in the following areas:

1. Level of Care
2. Service Plan
3. Qualified Provider
4. Health and Welfare
5. Administrative Authority
6. Financial Accountability

Once a baseline has been established, targets will be determined, and if acceptable progress toward the targets has not been made, remediation activities will be modified and prioritized with responsible resources and timelines identified.

All trends and prioritized remediation activity modifications will be reviewed annually or as needed with the DD Advisory Committee and Medicaid Director prior to implementation. Annually, data regarding all performance measures will be made available to all stakeholders and the public, via the Department's website.

This Quality Improvement System will apply to all DD System Waivers, but data will be stratified by waiver. Although we capture data system wide, we have the ability to disaggregate data based on funding source i.e., traditional waiver vs. self directed waiver.

A. Annual reports will be provided to the Medicaid Director regarding waiver compliance with each assurance.
B. Annual reports will be provided to the North Dakota Protection and Advocacy Project regarding incident management.
C. Annual reports will be provided to the Developmental Disabilities Advisory Committee on all performance measures and progress towards those measures.
D. Annual reports on all performance measures and all progress towards those measures will be made available to the general public on the Department's website.
E. Provider license renewal information and degree of compliance with licensure standards and agency applicable performance measures will be given to the license renewal applicant (Licensed DD Provider) annually.

Implementation Date: 03-31-10

**ii. System Improvement Activities**

| **Responsible Party** *(check each that applies):* | **Frequency of Monitoring and Analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☑ **Quarterly** |
| ☐ **Quality Improvement Committee** | ☐ **Annually** |
| ☐ **Other** Specify: | ☐ **Other** Specify: |

**b. System Design Changes**

**i.** Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The effectiveness of system design changes will be evident through ongoing monitoring activities using the same performance measures. Once performance measures are implemented and the DD Division has an initial baseline year of service experience, the DD Division will develop priorities. Prior to Waiver Year 2, the DD Division will request that a CMS Technical Assistance Contractor review performance measures and State Quality Improvement System strategies in order to provide recommendations for improvement and best practice methods.

**ii.** Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Based on the review of the Quality Management System, the DD Division will review the following on an annual basis:

(1) Information Technology needs
(2) Verify quality of data
(3) Verify quality of data analysis
(4) Identify strategy gaps
(5) Review Workflow Process
(6) Review the Sampling Methodology for appropriateness

Following review of the above items, necessary adjustments will be made to the Quality Improvement Strategy.

# Appendix I: Financial Accountability

## I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

An allowable cost-based retrospective rate setting system is utilized. Annually, provider's actual costs and revenue are audited by the DHS Provider Audit Unit. In order to be eligible for reimbursement, the provider must participate in the program audit and utilization review process established by the department. Providers under contract with the department to provide services to individuals with developmental disabilities must submit to the department, no less than annually, a statement of actual costs. Providers must disclose all costs and all revenues. Providers must identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. The final rate established per the program audit review process is payment for all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05. The audits include review of reported costs to determine that they are allowable according to the rules. Final rates are then determined by census data, revenue, and allowable costs. The audit is then settled with payback by the provider if payments exceed allowable costs. The process, allowable and non-allowable cost definitions, and accounting requirements are set out in North Dakota Administrative Code Chapter (NDAC) 75-04-05 and Purchase of Service requirements in NDAC 75-04-02.

For Self-Directed Services the Fiscal Agent contracted has developed an on-line balance sheet report that indicates total budget, expenditures and remaining funds. This information is available to families and Case Managers. If families request, a copy of the balance sheet report is mailed to them monthly or as requested. Families may also call the Fiscal Agent for updated information. The authorization process prevents over billing by the fiscal agent as the MMIS has edits that prohibit payments in excess of authorized budget limits. Central office staff monitor monthly budget program spend down reports generated through MMIS and monthly contract billings for fiscal agent services. As outlined in the contract with the North Dakota Department of Human Services, the fiscal agent also has agreed to have an independent audit conducted and will share the results.

The State agency responsible for conducting the state's financial audit is the Office of the State Auditor. An audit of the State of North Dakota Comprehensive Annual Financial Report is conducted annually by the State Auditor's Office. This audit involves examining, on a test basis, evidence supporting the revenues, expenditures and disclosures in the financial statements, assessing the accounting principles used and evaluating the overall financial statement presentation.

An agency audit of the Department of Human Services is performed every two years. This audit is a result of the statutory responsibility of the State Auditor to audit each state agency once every two years and is a report on internal control, on compliance with State and Federal laws, and on efficiency and effectiveness of agency operations.

The State Auditor's Office is also responsible for performing the Single Audit, which is a report on compliance with requirements applicable to each major program and on internal control over compliance, in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. The Single Audit is also conducted once every two years.

Each waiver service has a discreet service code and billings and payments are made through MMIS. Monthly payment reports by service code are generated in order to track and trend costs for each service. Annually, 372 reports are generated from MMIS identifying costs for each waiver service. For self directed services, the fiscal agent contract requires that expenditures be coded by service type. These reports are provided as requested.

In addition, individual authorizations track service utilization in order for the state to monitor the service costs and limitations.

# Appendix I: Financial Accountability

## Quality Improvement: Financial Accountability

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Financial Accountability**
***State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.***

**i. Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**
**(I-1) 100% compliance with NDAC 75-04-05 requirements for provider submission of cost reports and finalization of annual provider audits.**

**Data Source** (Select one):
**Financial audits**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☑ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☐ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☐ **Representative Sample**<br>Confidence Interval = |
| ☐ **Other**<br>Specify: | ☐ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☑ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**Performance Measure:**
**(I-2) 100% of sampled fiscal agent MMIS billings will match authorizations.**

**Data Source** (Select one):
**Reports to State Medicaid Agency on delegated Administrative functions**
If 'Other' is selected, specify:

| **Responsible Party for data collection/generation***(check each that applies):* | **Frequency of data collection/generation***(check each that applies):* | **Sampling Approach***(check each that applies):* |
|---|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** | ☐ **100% Review** |
| ☐ **Operating Agency** | ☐ **Monthly** | ☑ **Less than 100% Review** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** | ☑ **Representative Sample**<br>Confidence Interval = 95% |
| ☐ **Other**<br>Specify: | ☑ **Annually** | ☐ **Stratified**<br>Describe Group: |
| | ☐ **Continuously and Ongoing** | ☐ **Other**<br>Specify: |
| | ☐ **Other**<br>Specify: | |

**Data Aggregation and Analysis:**

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |

| **Responsible Party for data aggregation and analysis** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☑ **Annually** |
| | ☐ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**ii.** If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

**i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Samples are not pulled for review as ALL claims that do not pass edits built into the system are suspended within MMIS. The claims processing unit reviews all suspended claims and advises the provider if the claim is not properly coded. The provider will receive a remittance advise with a code indicating the cause of the suspension. The provider and DD Program Management then work together to correct the billing error.

During the provider audit process, if non-allowable costs are identified in the cost report, the costs are disallowed in the final rate determination.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

| **Responsible Party** *(check each that applies):* | **Frequency of data aggregation and analysis** *(check each that applies):* |
|---|---|
| ☑ **State Medicaid Agency** | ☐ **Weekly** |
| ☐ **Operating Agency** | ☐ **Monthly** |
| ☐ **Sub-State Entity** | ☐ **Quarterly** |
| ☐ **Other**<br>Specify: | ☐ **Annually** |
| | ☑ **Continuously and Ongoing** |
| | ☐ **Other**<br>Specify: |

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

○ **No**

**Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The DD Division is participating in the development of the new MMIS System to ensure that all DD Waiver issues are addressed in the new system when it is implemented.

Major changes need to be made in the Infant Development rate setting and payment methodology. To develop and implement those changes data collections must be completed and implementation support designed to prevent a negative impact on current service delivery. The process will need to include study of costs and current administrative code changes will be necessary. The changes will be developed and implemented by 1-01-10.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Program rates are primarily determined by the collective need (amount of services) of the individuals in the program, salary and fringe costs, and administration (fixed/operating costs). Retrospective rate-setting requires that an interim rate be established prior to the year in which it will be effective. Providers are required to submit a statement of budgeted costs to the department no less than annually so an interim rate may be determined. The determination of a final rate for all services begins with the reported cost of the provider's operations for that fiscal year. Once it has been determined that reported costs are allowable, reasonable, and client-related, those costs are compared to the reimbursements received through the interim rate. Settlements are made through a recoupment or refund to the department for an overpayment or an additional payment to the provider for an underpayment.

The approved level of DD participation for administrative and general client salaries will be determined from base year audited costs, plus adjustments for legislatively approved inflationary and/or hourly wage increases. The approved level of DD participation for direct service salaries is based on established hourly wage allowances, plus adjustments for legislatively approved inflationary and/or hourly wage increases. The approved level of DD participation for 'other' and property costs will be determined from base year audited costs, plus adjustments for legislatively approved inflationary increases. In order to be eligible for reimbursement, the provider must participate in the program audit and utilization review process established by the department. Providers under contract with the department to provide services to individuals with developmental disabilities must submit to the department, no less than annually, a statement of actual costs. Providers must disclose all costs and all revenues. Providers must identify income to offset costs when applicable in order that state financial participation not supplant or duplicate other funding sources. The final rate established per the program audit review process is payment for all allowable, reasonable, and actual costs for all elements necessary to the delivery of a basic service to eligible clients subject to limitations and cost offsets per North Dakota Administrative Code 75-04-05.

A number of opportunities are provided for public comment into the rate setting process. Base staffing ratios and allowable costs are stipulated in ND Administrative Code 75-04-05 which is promulgated through a public notice and hearing process as required by state law. The public notification list and comment solicitation for rules governing rate setting for the Waiver include a variety of stakeholders including the Arc-ND, Protection & Advocacy, Disabilities Consortium, DD Advisory Committee, DD service providers, legislators, other stakeholders and the general public. Salary and fringe costs and inflationary adjustments are determined by legislative appropriation and are subject to that public process. In addition, prior to beginning development of proposed budgets-including the waiver-the department held public hearings in all eight regional human service centers to solicit input. In addition, the DD Division participates in the Legislative Partnership Committee, a planning group--represented by the entities listed above plus other interested persons—that develops a legislative priorities agenda which includes rates and rate setting issues.

A number of service rates include added factors for absences in the unit rate (Day Habilitation, Infant Development) or provide retainer payments for absent days (30 days maximum per year: Congregate Care, MSLA, TCLF, Specialized Placement, ISLA, SLA, FCO and FCO III).

In the individualized rate programs (ISLA, Family Support), component rates are uniform (hourly costs for salaries and fringes and administration), then the amount of component units necessary to provide support are determined by assessed need. The ISLA program process results in a daily rate. In Home Support, a family support services (both agency and self directed) and Extended Services (self directed) are an hourly rate. Family Care Option and Family Care Option III are a daily rate.
The provider is reimbursed for services to a developmentally disabled person on the basis of reasonable (per NDAC 75-04-05-01.20 and 75 -04-05-10.3) and allowable cost. Reported allowable costs are included in determining the interim and final rate. The method of finalizing

the reimbursement rate per unit is through the use of the retrospective rate setting system.

Note: Adjustments for anticipated legislatively approved inflationary increases for all services have been included in the Cost Neutrality Demonstration in Appendix J.

Cost factors in determining interim rates for Residential Habilitation (Congregate Care MSLA, SLA, TCLF, and Specialized Placement), Infant Development, Extended Services and Day Supports include Administrative expenses, General Client (program supervision and management) Direct Care Staff salary and fringes, other (operating expenses). These expenses are based on allowable costs for each provider for a base year. Adjustments are then made for difficulty of care (as recommended by interdisciplinary teams and approved by the Regional DD Program Administrator and DD Division), approved inflationary increases, and changes in units budgeted.
ISLA, Parenting Support, In-Home Supports, Family Care Option, Family Care Option III, and Extended Home Health Care rates are developed from an Administrative cost reimbursement, program supervision and management reimbursement based on a difficulty of care schedule, and direct intervention time (direct support staff salary and fringes) as recommended by interdisciplinary teams and reviewed and approved by the Regional DD Program Administrator and the DD Division.

Adult Day Health and Homemaker rates are based on appropriation cap per unit of service plus an Administrative expense for agency providers. Providers select a rate up to the cap.

Adult Family Foster Care rates are determined according to a rate worksheet completed by the Regional Program Manager which assesses actual intervention needs of the individual. The resulting score yields a monthly reimbursement. Relief care may be provided according to intensity of support needs.

Environmental Supports/Modifications and Equipment and Supplies rates are determined by the individual within an individualized budget developed with the DD Program Manager and approved by the DD Regional Program Administrator and the DD Division.

Behavioral Consultation: The DD Division will look at comparable services being delivered across the state to determine the maximum hourly rate. The consumer/legal decision maker, other person centered service plan members, and the program manager will recommend the maximum number of hours per month which is reviewed/approved by the Regional DD Program Administrator and the DD Division.

Transportation for Financially Responsible Caregivers: The rate is based on prior authorization of mileage and transportation related costs such as lodging and meals. The state reimbursement guidelines regarding transportation reimbursement are followed as they are for Medicaid State Plan transportation reimbursement. A transportation grid was developed to assure consistency in determining when the state plan will reimburse transportation and when it can be reimbursed through the waiver.

All associated costs (i.e. mileage,lodging, meals) must be authorized before reimbursement for transportation can occur. The authorization is a part of the Person Centered Service Planning process. The authorization is also approved by the DD Division.

Financially responsible caregivers (parents of minor children) cannot become Medicaid Transportation Providers through the Medicaid State Plan. To receive this waiver service, eligible consumers must be living in a family home with their financially responsible caregiver.

We will not reimburse travel within their own community. For travel within the State, reimbursement will occur after the first 150 miles for each month. Meals and lodging are not provided for in-state travel.

Limited to $5,200 per State Fiscal Year. Mileage included in individual authorization will not exceed map miles between individuals dwelling and point of service being accessed.

**b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Billings flow directly from the provider of service to the State’s claim payment system for all services except self-directed services. In self-directed services, participants direct bills or invoices to the fiscal agent. The fiscal agent pays the vendor or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one)*:

**No. State or local government agencies do not certify expenditures for waiver services.**

**Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DD Program Managers determine Level of Care as a prerequisite for waiver service eligibility (see Level of Care Determination Assurances above). DD Program Managers then authorize services on the Individual Service Plan in Therap. Edits are not built into the MMIS system to prevent payment for services not authorized. However, the subsequent checks described (numbered 1-7) are in place to assure services are received as billed.

The DD Claims reviewer receives weekly queries of Therap data for individual changes to Level of Care and start or termination of waivered services. The Level of Care determinations are entered into an MMIS file with codes for Nursing Facility or ICF/MR level of care or waiver services. Each waiver, NF level of care, and ICF/MR level of care have individual codes. Only one code can be entered per individual assuring that services cannot be duplicated. The Individual Service Plan information authorizing a waiver service is entered into a DD eligibility file (Natural System) which includes the service authorized, dates for which authorized, provider number and Medicaid number and rate and frequency (for individualized rates).

Another file contains provider rates by provider number. Providers bill for services by client Medicaid number, service code, provider number, dates of service and units of service. Numerous edits assure that claims are paid properly. In order for a claim to be paid for waiver services, the system 1) determines the individual is currently eligible for MA, 2) the person has a current level of care screening and code for DD waiver services, 3) the service is currently authorized by DD Program Managers,
4) the billed rate is correct for that individual, provider, or program, 5) units billed are within authorized amounts, 6) units billed are within maximum allowable,
7) there are no competing claims for the same service and time period.
If any of the above are absent from the system or conflict, the claim will suspend or be denied. The claims reviewer then receives reports of suspended or denied claims and the reason. For individualized rates (ISLA, Family Support Services, and Extended Services) DD Program Managers complete an individualized authorization document. Through an automated work flow process, this is forwarded to the Regional DD Program Administrator for review and approval and then to the DD Division for review and approval. With final DD Division approval it is forwarded to the DD Claims reviewer to enter the authorized amount and dates of service, the rate, and authorized provider. Additional checks are in place to assure services are received as billed. At least every 90 days the DD Program Manager meets with the individual to complete a Quality Enhancement Review. Included in that review is whether or not the service has been provided and the individual's satisfaction with it. At that time the DD Program Manager also updates the previous quarter's Family Support Services

authorization to reflect actual hours delivered.
Providers are required to maintain census reports by individual to verify that services were provided.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

(●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

( ) **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

( ) **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
( ) **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
(✓) **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal agent is used for self-directed service payments. In self-directed services, participants direct bills or invoices to the fiscal agent. The fiscal agent pays the vendor or reimburses the participant, codes the claims as to specific type, and bills through the state claims payment system. On-line accounts are available for participants, DD Program Managers and DD Program Administrators to

monitor payments, individual budgets, and account balances. Quarterly reports of the fiscal agent are available to the DD Division and the fiscal agent annually provides detail for the 372 reports.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◉ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

○ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

◉ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Two of the Department of Human Services Regional Human Service Centers provide direct services to participants. Rates are based on actual costs.

Services provided are Day Supports and Extended Services. A number of county social service boards are providers of Homemaker Services. Rates are set in the same manner as for all agency providers.

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

*Check each that applies:*

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

*Check each that applies:*

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board rates are established by providers according to the provisions of NDAC 75-04-05. Those costs are not allowable in costs claimed by the provider for waiver services. The provider collects the room and board costs directly from individuals receiving services.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services*** *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- **Nominal deductible**
- **Coinsurance**
- **Co-Payment**
- **Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

**b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/MR**

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1 | 25025.19 | 3083.00 | 28108.19 | 133780.00 | 4431.00 | 138211.00 | 110102.81 |
| 2 | 27562.03 | 3237.00 | 30799.03 | 140469.00 | 4653.00 | 145122.00 | 114322.97 |
| 3 | 28482.03 | 3399.00 | 31881.03 | 147492.00 | 4885.00 | 152377.00 | 120495.97 |

| Col. 1 | Col. 2 | Col. 3 | Col. 4 | Col. 5 | Col. 6 | Col. 7 | Col. 8 |
|---|---|---|---|---|---|---|---|
| Year | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 4 | 31285.16 | 3569.00 | 34854.16 | 154867.00 | 5129.00 | 159996.00 | 125141.84 |
| 5 | 34235.38 | 3747.00 | 37982.38 | 162610.00 | 5386.00 | 167996.00 | 130013.62 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Number Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |
|---|---|---|
| | | Level of Care: |
| | | ICF/MR |
| **Year 1** | **4000** | 4000 |
| **Year 2** | **4100** | 4100 |
| **Year 3** | **4345** | 4345 |
| **Year 4** | **4450** | 4450 |
| **Year 5** | **4555** | 4555 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The State has further determined an estimate of average length of stay as it would apply to the merging of the two waivers. Data from the most recent Self Directed Supports approved 372(2009)and a query on the Traditional waiver for the period 4/1/10-2/23/11 was calculated and combined and the estimate for average length of stay is 321.40. The rationale for collecting the data from the approved 372 and the query is that, at the time of the 372 report, Self Directed Supports were not included in the Traditional waiver. Therefore, the State felt that using the 372 for the Traditional waiver would not accurately reflect the current numbers.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Costs were based on actual current expenditures and utilization for existing waiver services. New waiver service utilization estimates are based on utilization in similar programs and indications of need from public input. Service rates were estimated based on similar component costs (such as per hour direct contact staff reimbursement) in existing waiver services. Costs are inflated annually by 7% which is the inflator utilized in the Departments budget proposal to the legislature for the 2009-11 biennium.

Transportation estimates were arrived at by totaling mileage and lodging and meal reimbursments and dividing by the total number of trips. Some families are reimbursed mileage for in state trips, while others are reimbursed for lodging, meals and mileage for longer out of state trips.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on actual costs from years 1 to 4 of the current waiver. Costs increases were extrapolated to year 1 of the renewal and increased annually by 5% which is the average annual cost increase from year 1 to year 4 of the current waiver.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on actual costs from years 1 to 4 of the current waiver. Costs increases were extrapolated to year 1 of the renewal and increased annually by 5% which is the average annual cost increase from year 1 to year 4 of the current waiver.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Based on actual costs from years 1 to 4 of the current waiver. Costs increases were extrapolated to year 1 of the renewal and increased annually by 5% which is the average annual cost increase from year 1 to year 4 of the current waiver.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

| Waiver Services |  |
|---|---|
| Adult Day Health | |
| Day Habilitation | |
| Extended Services | |
| Homemaker | |
| Residential Habilitation | |
| Extended Home Health Care | |
| Adult Family Foster Care | |
| Behavioral Consultation | |
| Environmental Supports/Modifications | |
| Equipment and Supplies | |
| Family Care Option | |
| In-Home Supports | |
| Infant Development | |
| Parenting Support | |
| Transportation Costs for Financially Responsible Caregiver | |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | **17578.08** |
| Adult Day Health | 1/2 day | 3 | 208.00 | 28.17 | **17578.08** | |
| **Day Habilitation Total:** | | | | | | **23468006.40** |
| Day Habilitation | hour | 1028 | 1740.00 | 13.12 | **23468006.40** | |
| **Extended Services Total:** | | | | | | **2680368.00** |
| Extended Services | hour | 285 | 320.00 | 29.39 | **2680368.00** | |
| **Homemaker Total:** | | | | | | **54756.00** |
| Homemaker | 15 minute | 24 | 650.00 | 3.51 | **54756.00** | |
| **Residential Habilitation Total:** | | | | | | **57528900.00** |
| Congregate Care | day | 1341 | 325.00 | 132.00 | **57528900.00** | |
| Minimally Supervised Living Arrangements | day | 0 | 0.00 | 132.00 | **0.00** | |
| Transitional Community Living Facility | day | 0 | 0.00 | 132.00 | **0.00** | |
| Supported Living Arrangement | day | 0 | 0.00 | 132.00 | **0.00** | |
| Individualized Supported Living Arrangement | day | 0 | 0.00 | 132.00 | **0.00** | |
| Family Care Option III | day | 0 | 0.00 | 132.00 | **0.00** | |
| Residential Habilitation | day | 0 | 0.00 | 132.00 | **0.00** | |
| **Extended Home Health Care Total:** | | | | | | **982800.00** |
| Extended Home Health Care | hour | 9 | 3120.00 | 35.00 | **982800.00** | |
| **Adult Family Foster Care Total:** | | | | | | **372402.00** |
| Adult Family Foster Care | day | 30 | 340.00 | 36.51 | **372402.00** | |
| **Behavioral Consultation Total:** | | | | | | **27500.00** |
| Behavioral Consultation | hour | 25 | 22.00 | 50.00 | **27500.00** | |
| **Environmental Supports/Modifications Total:** | | | | | | **42000.00** |
| Environmental Supports/Modifications | item | 14 | 2.00 | 1500.00 | **42000.00** | |
| **Equipment and Supplies Total:** | | | | | | **148500.00** |
| Equipment and Supplies | item | 220 | 5.00 | 135.00 | **148500.00** | |
| **Family Care Option Total:** | | | | | | **0.00** |
| Family Care Option | day | 0 | 0.00 | 90.00 | **0.00** | |
| **In-Home Supports Total:** | | | | | | **7824250.00** |

| | |
|---|---|
| **GRAND TOTAL:** | **100100753.08** |
| **Total Estimated Unduplicated Participants:** | **4000** |
| **Factor D (Divide total by number of participants):** | **25025.19** |
| **Average Length of Stay on the Waiver:** | 310 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| In-Home Supports | hour | 700 | 425.00 | 26.30 | **7824250.00** | |
| **Infant Development Total:** | | | | | | **6262227.00** |
| Evaluations/Assessments | evaluations | 1367 | 180.00 | 25.45 | **6262227.00** | |
| IFSP/IFSP Review | IFSP | 0 | 0.00 | 25.45 | **0.00** | |
| Home Visits | Home Visits | 0 | 0.00 | 25.45 | **0.00** | |
| Consultations | consultations | 0 | 0.00 | 25.45 | **0.00** | |
| Infant Development | Infant Development | 0 | 0.00 | 25.45 | **0.00** | |
| **Parenting Support Total:** | | | | | | **180585.60** |
| Parenting Support | hour | 20 | 208.00 | 43.41 | **180585.60** | |
| **Transportation Costs for Financially Responsible Caregiver Total:** | | | | | | **510880.00** |
| Transportation Costs for Financially Responsible Caregiver | trip | 412 | 4.00 | 310.00 | **510880.00** | |
| In State | trip | 0 | 0.00 | 310.00 | **0.00** | |
| Out of State | trip | 0 | 0.00 | 310.00 | **0.00** | |
| | | | | **GRAND TOTAL:** | | **100100753.08** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4000** |
| | | | | **Factor D (Divide total by number of participants):** | | **25025.19** |
| | | | | **Average Length of Stay on the Waiver:** | | 310 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | **18807.36** |
| Adult Day Health | 1/2 day | 3 | 208.00 | 30.14 | **18807.36** | |
| **Day Habilitation Total:** | | | | | | **26359538.40** |
| Day Habilitation | hour | 1079 | 1740.00 | 14.04 | **26359538.40** | |
| **Extended Services Total:** | | | | | | **3009136.00** |
| | | | | **GRAND TOTAL:** | | **113004326.61** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4100** |
| | | | | **Factor D (Divide total by number of participants):** | | **27562.03** |
| | | | | **Average Length of Stay on the Waiver:** | | 310 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Extended Services | hour | 299 | 320.00 | 31.45 | **3009136.00** | |
| **Homemaker Total:** | | | | | | **61100.00** |
| Homemaker | 15 minute | 25 | 650.00 | 3.76 | **61100.00** | |
| **Residential Habilitation Total:** | | | | | | **64631424.00** |
| Congregate Care | day | 1408 | 325.00 | 141.24 | **64631424.00** | |
| Minimally Supervised Living Arrangements | day | 0 | 0.00 | 141.24 | **0.00** | |
| Transitional Community Living Facility | day | 0 | 0.00 | 141.24 | **0.00** | |
| Supported Living Arrangement | day | 0 | 0.00 | 141.24 | **0.00** | |
| Individualized Supported Living Arrangement | day | 0 | 0.00 | 141.24 | **0.00** | |
| Family Care Option III | day | 0 | 0.00 | 141.24 | **0.00** | |
| Residential Habilitation | day | 0 | 0.00 | 141.24 | **0.00** | |
| **Extended Home Health Care Total:** | | | | | | **1652508.00** |
| Extended Home Health Care | hour | 11 | 3120.00 | 48.15 | **1652508.00** | |
| **Adult Family Foster Care Total:** | | | | | | **425081.60** |
| Adult Family Foster Care | day | 32 | 340.00 | 39.07 | **425081.60** | |
| **Behavioral Consultation Total:** | | | | | | **30602.00** |
| Behavioral Consultation | hour | 26 | 22.00 | 53.50 | **30602.00** | |
| **Environmental Supports/Modifications Total:** | | | | | | **48150.00** |
| Environmental Supports/Modifications | item | 15 | 2.00 | 1605.00 | **48150.00** | |
| **Equipment and Supplies Total:** | | | | | | **166839.75** |
| Equipment and Supplies | item | 231 | 5.00 | 144.45 | **166839.75** | |
| **Family Care Option Total:** | | | | | | **0.00** |
| Family Care Option | day | 0 | 0.00 | 90.00 | **0.00** | |
| **In-Home Supports Total:** | | | | | | **8790232.50** |
| In-Home Supports | hour | 735 | 425.00 | 28.14 | **8790232.50** | |
| **Infant Development Total:** | | | | | | **7033509.00** |
| Evaluations/Assessments | day | 1435 | 180.00 | 27.23 | **7033509.00** | |
| IFSP/IFSP Review | IFSP | 0 | 0.00 | 27.23 | **0.00** | |
| Home Visits | Home Visits | 0 | 0.00 | 27.23 | **0.00** | |
| Consultations | consultations | 0 | 0.00 | 27.23 | **0.00** | |

| | |
|---|---|
| **GRAND TOTAL:** | **113004326.61** |
| **Total Estimated Unduplicated Participants:** | **4100** |
| **Factor D (Divide total by number of participants):** | **27562.03** |
| **Average Length of Stay on the Waiver:** | 310 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Infant Development | Infant Development | 0 | 0.00 | 27.23 | 0.00 | |
| **Parenting Support Total:** | | | | | | 202893.60 |
| Parenting Support | 1 hour | 21 | 208.00 | 46.45 | 202893.60 | |
| **Transportation Costs for Financially Responsible Caregiver Total:** | | | | | | 574504.40 |
| Transportation Costs for Financially Responsible Caregiver | trip | 433 | 4.00 | 331.70 | 574504.40 | |
| In State | trip | 0 | 0.00 | 331.70 | 0.00 | |
| Out of State | trip | 0 | 0.00 | 331.70 | 0.00 | |
| | | | | GRAND TOTAL: | | 113004326.61 |
| | | | | Total Estimated Unduplicated Participants: | | 4100 |
| | | | | Factor D (Divide total by number of participants): | | 27562.03 |
| | | | | Average Length of Stay on the Waiver: | | 310 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | 20124.00 |
| Adult Day Health | 1/2 day | 3 | 208.00 | 32.25 | 20124.00 | |
| **Day Habilitation Total:** | | | | | | 29610728.40 |
| Day Habilitation | hour | 1133 | 1740.00 | 15.02 | 29610728.40 | |
| **Extended Services Total:** | | | | | | 3402688.00 |
| Extended Services | hour | 316 | 320.00 | 33.65 | 3402688.00 | |
| **Homemaker Total:** | | | | | | 67938.00 |
| Homemaker | 15 minute | 26 | 650.00 | 4.02 | 67938.00 | |
| **Residential Habilitation Total:** | | | | | | 67426671.00 |
| Congregate Care | day | 36 | 325.00 | 55.77 | 652509.00 | |
| Minimally Supervised Living Arrangements | day | 124 | 325.00 | 176.42 | 7109726.00 | |
| | | | | GRAND TOTAL: | | 123754441.48 |
| | | | | Total Estimated Unduplicated Participants: | | 4345 |
| | | | | Factor D (Divide total by number of participants): | | 28482.03 |
| | | | | Average Length of Stay on the Waiver: | | 325 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Transitional Community Living Facility | day | 101 | 325.00 | 173.83 | **5705969.75** | |
| Supported Living Arrangement | day | 162 | 325.00 | 11.79 | **620743.50** | |
| Individualized Supported Living Arrangement | day | 1027 | 325.00 | 152.45 | **50883998.75** | |
| Family Care Option III | day | 28 | 325.00 | 269.64 | **2453724.00** | |
| Residential Habilitation | day | 0 | 325.00 | 161.71 | **0.00** | |
| **Extended Home Health Care Total:** | | | | | | **1768166.40** |
| Extended Home Health Care | hour | 11 | 3120.00 | 51.52 | **1768166.40** | |
| **Adult Family Foster Care Total:** | | | | | | **468996.00** |
| Adult Family Foster Care | day | 33 | 340.00 | 41.80 | **468996.00** | |
| **Behavioral Consultation Total:** | | | | | | **66753.50** |
| Behavioral Consultation | hour | 53 | 22.00 | 57.25 | **66753.50** | |
| **Environmental Supports/Modifications Total:** | | | | | | **137388.00** |
| Environmental Supports/Modifications | item | 40 | 2.00 | 1717.35 | **137388.00** | |
| **Equipment and Supplies Total:** | | | | | | **241886.40** |
| Equipment and Supplies | item | 313 | 5.00 | 154.56 | **241886.40** | |
| **Family Care Option Total:** | | | | | | **277420.00** |
| Family Care Option | day | 11 | 325.00 | 77.60 | **277420.00** | |
| **In-Home Supports Total:** | | | | | | **10635213.32** |
| In-Home Supports | hour | 778 | 454.00 | 30.11 | **10635213.32** | |
| **Infant Development Total:** | | | | | | **8644934.62** |
| Evaluations/Assessments | Evaluations/Assessm | 1684 | 1.00 | 462.24 | **778412.16** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 1507 | 3.00 | 447.26 | **2022062.46** | |
| Home Visits | Home Visits | 1000 | 35.00 | 134.82 | **4718700.00** | |
| Consultations | Consultations | 1000 | 4.00 | 281.44 | **1125760.00** | |
| Infant Development | Infant Development | 0 | 0.00 | 29.14 | **0.00** | |
| **Parenting Support Total:** | | | | | | **227427.20** |
| Parenting Support | 1 hour | 22 | 208.00 | 49.70 | **227427.20** | |
| **Transportation Costs for Financially Responsible Caregiver Total:** | | | | | | **758106.64** |
| Transportation Costs for Financially Responsible Caregiver | trip | 0 | 0.00 | 354.92 | **0.00** | |
| In State | trip | 177 | 5.00 | 171.32 | **151618.20** | |

| | |
|---|---|
| **GRAND TOTAL:** | **123754441.48** |
| **Total Estimated Unduplicated Participants:** | **4345** |
| **Factor D (Divide total by number of participants):** | **28482.03** |
| **Average Length of Stay on the Waiver:** | 325 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Out of State | trip | 401 | 2.00 | 756.22 | **606488.44** | |
| | | | | **GRAND TOTAL:** | | **123754441.48** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4345** |
| | | | | **Factor D (Divide total by number of participants):** | | **28482.03** |
| | | | | **Average Length of Stay on the Waiver:** | | 325 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 4**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | **21534.24** |
| Adult Day Health | 1/2 day | 3 | 208.00 | 34.51 | **21534.24** | |
| **Day Habilitation Total:** | | | | | | **33274542.00** |
| Day Habilitation | hour | 1190 | 1740.00 | 16.07 | **33274542.00** | |
| **Extended Services Total:** | | | | | | **3824640.00** |
| Extended Services | hour | 332 | 320.00 | 36.00 | **3824640.00** | |
| **Homemaker Total:** | | | | | | **78260.00** |
| Homemaker | 15 minute | 28 | 650.00 | 4.30 | **78260.00** | |
| **Residential Habilitation Total:** | | | | | | **75715211.00** |
| Congregate Care | day | 39 | 325.00 | 59.67 | **756317.25** | |
| Minimally Supervised Living Arrangements | day | 129 | 325.00 | 188.77 | **7914182.25** | |
| Transitional Community Living Facility | day | 103 | 325.00 | 186.00 | **6226350.00** | |
| Supported Living Arrangement | day | 170 | 325.00 | 12.62 | **697255.00** | |
| Individualized Supported Living Arrangement | day | 1081 | 325.00 | 163.12 | **57308134.00** | |
| Family Care Option III | day | 30 | 325.00 | 288.51 | **2812972.50** | |
| Residential Habilitation | day | 0 | 325.00 | 173.03 | **0.00** | |
| **Extended Home Health Care Total:** | | | | | | **2064067.20** |
| | | | | **GRAND TOTAL:** | | **139218953.97** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4450** |
| | | | | **Factor D (Divide total by number of participants):** | | **31285.16** |
| | | | | **Average Length of Stay on the Waiver:** | | 325 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| Extended Home Health Care | hour | 12 | 3120.00 | 55.13 | **2064067.20** | |
| **Adult Family Foster Care Total:** | | | | | | **532287.00** |
| Adult Family Foster Care | day | 35 | 340.00 | 44.73 | **532287.00** | |
| **Behavioral Consultation Total:** | | | | | | **76807.50** |
| Behavioral Consultation | hour | 57 | 22.00 | 61.25 | **76807.50** | |
| **Environmental Supports/Modifications Total:** | | | | | | **161705.28** |
| Environmental Supports/Modifications | item | 44 | 2.00 | 1837.56 | **161705.28** | |
| **Equipment and Supplies Total:** | | | | | | **271223.20** |
| Equipment and Supplies | item | 328 | 5.00 | 165.38 | **271223.20** | |
| **Family Care Option Total:** | | | | | | **344253.00** |
| Family Care Option | day | 13 | 325.00 | 81.48 | **344253.00** | |
| **In-Home Supports Total:** | | | | | | **12043425.60** |
| In-Home Supports | hour | 828 | 460.00 | 31.62 | **12043425.60** | |
| **Infant Development Total:** | | | | | | **9705919.92** |
| Evaluations/Assessments | Evaluations/Assesme | 1819 | 1.00 | 494.60 | **899677.40** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 1582 | 3.00 | 478.57 | **2271293.22** | |
| Home Visits | Home Visits | 1045 | 35.00 | 144.26 | **5276309.50** | |
| Consultations | Consultations | 1045 | 4.00 | 301.11 | **1258639.80** | |
| Infant Development | Infant Development | 0 | 0.00 | 31.18 | **0.00** | |
| **Parenting Support Total:** | | | | | | **254413.12** |
| Parenting Support | 1 hour | 23 | 208.00 | 53.18 | **254413.12** | |
| **Transportation Costs for Financially Responsible Caregiver Total:** | | | | | | **850664.91** |
| Transportation Costs for Financially Responsible Caregiver | trip | 0 | 0.00 | 379.76 | **0.00** | |
| In State | trip | 185 | 5.00 | 183.93 | **170135.25** | |
| Out of State | trip | 421 | 2.00 | 808.23 | **680529.66** | |
| | | | | **GRAND TOTAL:** | | **139218953.97** |
| | | | | **Total Estimated Unduplicated Participants:** | | **4450** |
| | | | | **Factor D (Divide total by number of participants):** | | **31285.16** |
| | | | | **Average Length of Stay on the Waiver:** | | 325 |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Adult Day Health Total:** | | | | | | **30725.76** |
| Adult Day Health | 1/2 day | 4 | 208.00 | 36.93 | **30725.76** | |
| **Day Habilitation Total:** | | | | | | **37410000.00** |
| Day Habilitation | hour | 1250 | 1740.00 | 17.20 | **37410000.00** | |
| **Extended Services Total:** | | | | | | **4289587.20** |
| Extended Services | hour | 348 | 320.00 | 38.52 | **4289587.20** | |
| **Homemaker Total:** | | | | | | **86710.00** |
| Homemaker | 15 minute | 29 | 650.00 | 4.60 | **86710.00** | |
| **Residential Habilitation Total:** | | | | | | **85014182.50** |
| Congregate Care | day | 42 | 325.00 | 63.85 | **871552.50** | |
| Minimally Supervised Living Arrangements | day | 136 | 325.00 | 201.98 | **8927516.00** | |
| Transitional Community Living Facility | day | 110 | 325.00 | 199.02 | **7114965.00** | |
| Supported Living Arrangement | day | 180 | 325.00 | 13.50 | **789750.00** | |
| Individualized Supported Living Arrangement | day | 1130 | 325.00 | 174.54 | **64099815.00** | |
| Family Care Option III | day | 32 | 325.00 | 308.71 | **3210584.00** | |
| Residential Habilitation | day | 0 | 325.00 | 185.14 | **0.00** | |
| **Extended Home Health Care Total:** | | | | | | **2208585.60** |
| Extended Home Health Care | hour | 12 | 3120.00 | 58.99 | **2208585.60** | |
| **Adult Family Foster Care Total:** | | | | | | **585806.40** |
| Adult Family Foster Care | day | 36 | 340.00 | 47.86 | **585806.40** | |
| **Behavioral Consultation Total:** | | | | | | **86512.80** |
| Behavioral Consultation | hour | 60 | 22.00 | 65.54 | **86512.80** | |
| **Environmental Supports/Modifications Total:** | | | | | | **184821.86** |
| Environmental Supports/Modifications | item | 47 | 2.00 | 1966.19 | **184821.86** | |
| **Equipment and Supplies Total:** | | | | | | **302601.60** |
| Equipment and Supplies | item | 342 | 5.00 | 176.96 | **302601.60** | |

| | |
|---|---|
| **GRAND TOTAL:** | **155942153.35** |
| **Total Estimated Unduplicated Participants:** | **4555** |
| **Factor D (Divide total by number of participants):** | **34235.38** |
| **Average Length of Stay on the Waiver:** | 325 |

| Waiver Service/ Component | Unit | # Users | Avg. Units Per User | Avg. Cost/ Unit | Component Cost | Total Cost |
|---|---|---|---|---|---|---|
| **Family Care Option Total:** | | | | | | **417056.25** |
| Family Care Option | day | 15 | 325.00 | 85.55 | **417056.25** | |
| **In-Home Supports Total:** | | | | | | **13206960.00** |
| In-Home Supports | hour | 850 | 468.00 | 33.20 | **13206960.00** | |
| **Infant Development Total:** | | | | | | **10882069.96** |
| Evaluations/Assessments | Evaluations/Assessm | 1931 | 1.00 | 529.22 | **1021923.82** | |
| IFSP/IFSP Review | IFSP/IFSP Review | 1662 | 3.00 | 512.07 | **2553181.02** | |
| Home Visits | Home Visits | 1092 | 35.00 | 154.36 | **5899639.20** | |
| Consultations | Consultations | 1092 | 4.00 | 322.19 | **1407325.92** | |
| Infant Development | Infant Development | 0 | 0.00 | 33.36 | **0.00** | |
| **Parenting Support Total:** | | | | | | **284044.80** |
| Parenting Support | 1 hour | 24 | 208.00 | 56.90 | **284044.80** | |
| **Transportation Costs for Financially Responsible Caregiver Total:** | | | | | | **952488.62** |
| Transportation Costs for Financially Responsible Caregiver | trip | 0 | 0.00 | 406.35 | **0.00** | |
| In State | trip | 194 | 5.00 | 196.39 | **190498.30** | |
| Out of State | trip | 442 | 2.00 | 861.98 | **761990.32** | |

| | |
|---|---|
| **GRAND TOTAL:** | **155942153.35** |
| **Total Estimated Unduplicated Participants:** | **4555** |
| **Factor D (Divide total by number of participants):** | **34235.38** |
| **Average Length of Stay on the Waiver:** | 325 |